

## U.S. DEPARTMENT OF LABOR

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ADVISORY BOARD ON TOXIC SUBSTANCES  
AND WORKER HEALTH

+ + + + +

WEDNESDAY  
NOVEMBER 15, 2023

+ + + + +

The Advisory Board met at the Eldorado Hotel & Spa, Zia Boardrooms, 309 W San Francisco Street, Santa Fe, New Mexico, at 9:00 a.m., Steven Markowitz, Chair, presiding.

SCIENTIFIC COMMUNITY

AARON BOWMAN  
MARK CATLIN  
GEORGE FRIEDMAN-JIMENEZ\*  
MIKE VAN DYKE

MEDICAL COMMUNITY

MARIANNE CLOEREN  
STEVEN MARKOWITZ, Chair  
MAREK MIKULSKI  
KEVIN VLAHOVICH

CLAIMANT COMMUNITY

JIM H. KEY  
GAIL SPLETT  
KIRK DOMINA

DESIGNATED FEDERAL OFFICIAL

RYAN JANSEN

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ALSO PRESENT

KEVIN BIRD, SIDEM  
D'LANIE BLAZE, CORE Advocacy for Nuclear &  
Aerospace Workers  
SOPHIA CALBAZA, DOL  
AMANDA FALLON, DOL  
TYLER GREEN, DOL  
DEB JERISON, Energy Employees Claimant  
Assistance Project  
REGINA GRIEGO-KELLEHER, DOE  
GREG LEWIS, DOE  
MATT MILLER, Field Representative,  
Congresswoman Teresa Leger Fernandez  
RACHEL POND, DOL  
CARRIE RHOADS, DOL  
TONYA TAYLOR, DOL  
PETER TURCIC, Paragon\*  
JOHN VANCE, DOL\*

\*Present via video-teleconference

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1 P-R-O-C-E-E-D-I-N-G-S

2 (9:01 a.m.)

3 MR. JANSEN: Good morning, everyone.  
4 My name is Ryan Jansen, and I'm the Designated  
5 Federal Officer for the Department of Labor's  
6 Advisory Board on Toxic Substances and Worker  
7 Health. I would like to welcome you to today's  
8 meeting of the Advisory Board here in Santa Fe,  
9 New Mexico. Today is Wednesday, November 15th,  
10 2023, and we are scheduled to meet from 9:00  
11 a.m. to 5:00 p.m. Mountain Time.

12 At the outset, I'd like to express  
13 my appreciation for the hard work of the Board  
14 members in preparing for this meeting, and  
15 their forthcoming deliberations. I'd also like  
16 to thank Carrie Rhoads, from the Department of  
17 Labor, and Kevin Bird, our logistics  
18 contractor, who are both with me here today,  
19 for their work organizing this meeting.

20 The Board's website, which can be  
21 found at [dol.gov/owcp/energy/regs/](https://dol.gov/owcp/energy/regs/compliance/advisoryboard.htm)  
22 [compliance/advisoryboard.htm](https://dol.gov/owcp/energy/regs/compliance/advisoryboard.htm), has a page

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1 dedicated to this meeting. The page contains  
2 materials submitted to us in advance of the  
3 meeting, and will include any materials that  
4 are provided by our presenters throughout the  
5 next day and a half. There, you can also find  
6 today's agenda, as well as instructions for  
7 participating remotely in both the meeting and  
8 the public comment period later today.

9 If any of the virtual participants  
10 have technical difficulties during this  
11 meeting, please email us at  
12 [energyadvisoryboard@dol.gov](mailto:energyadvisoryboard@dol.gov). If you are  
13 joining by Webex, please note that outside of  
14 the public comment period this afternoon, this  
15 session is for viewing only, and microphones  
16 will be muted for non-advisory Board members.  
17 So the public may listen in, but not  
18 participate in the Board's discussion during  
19 the meeting.

20 If you are participating remotely  
21 and wish to provide a public comment, please  
22 email [energyadvisoryboard@dol.gov](mailto:energyadvisoryboard@dol.gov) and request

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1 to make a comment. Be sure to include your  
2 name in the request. If you are participating  
3 remotely and need to provide your comment via  
4 telephone, not Webex, please include the phone  
5 number that you will be dialing in from so that  
6 we can unmute your line when it is your turn to  
7 make a public comment.

8 The public comment period opens at  
9 4:15 p.m. Mountain Time this afternoon. Please  
10 note that the public comment period isn't a  
11 question and answer session, but rather an  
12 opportunity for the public to provide comments  
13 about the topics being discussed and considered  
14 by the Board. If for any reason the Board  
15 members require clarification on an issue that  
16 requires participation from the public, the  
17 Board may request such information through the  
18 Chair or myself.

19 A transcript in meetings will be  
20 prepared from today's meeting. As the  
21 Designated Federal Officer, I see that the  
22 minutes are prepared and ensure that they are

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1 certified by the Chair. The minutes of today's  
2 meeting will be available on the Board's  
3 website no later than 90 calendar days from  
4 today, but if they're available sooner, they'll  
5 be posted sooner. Although formal minutes will  
6 be prepared according to the regulations, we  
7 also prepare verbatim transcripts, and they  
8 should be available on the Board's website  
9 within 30 days.

10 During the discussions today, please  
11 speak clearly enough for the transcriber to  
12 understand. When you begin speaking,  
13 especially at the start of the meeting, make  
14 sure that you state your name so that it's  
15 clear who is saying what. I would also like to  
16 ask that our transcriber please let us know if  
17 you have trouble hearing anyone or any of the  
18 information that is being provided.

19 As always, I would like to remind  
20 Advisory Board members that there are some  
21 materials that have been provided to you in  
22 your capacity as special government employees

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1 and members of the Board which are not suitable  
2 for public disclosure and cannot be shared or  
3 discussed publicly, including during this  
4 meeting. Please be aware of this throughout  
5 the discussions today and tomorrow. The  
6 materials can be discussed in a general way  
7 which does not include any personally  
8 identifiable information, or PII, such as  
9 names, addresses, or a doctor's name if we are  
10 discussing a case.

11 I'm looking forward to working with  
12 everyone at this meeting and hearing the next  
13 discussions over the next day and a half. And  
14 with that, I convene this meeting of the  
15 Advisory Board on Toxic Substances and Worker  
16 Health. I will now turn it over to Dr.  
17 Markowitz for introductions.

18 CHAIR MARKOWITZ: Good morning.  
19 Welcome, members of the Board, members of the  
20 public, people from the Department of Labor,  
21 people from the Department of Energy, and  
22 members of the public who are online as well.

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1 And see Dr. Friedman-Jimenez, as you -- we can  
2 see you loud and clear. So that's excellent.

3 I want to thank Kevin Bird and his  
4 crew for putting this together, and of course  
5 to Ryan Jansen and Carrie Rhoads for all the  
6 preparation for this -- for today's meeting. I  
7 also want to thank -- I don't see Greg Lewis  
8 here yet, from the Department of Energy, but he  
9 arranged for us to have a tour yesterday, which  
10 was a very good tour of Los Alamos. We were  
11 lucky enough to get an excellent historian who  
12 had a lot to say, I would -- you know, and  
13 about the history, that -- particularly the  
14 early history of Los Alamos and the Manhattan  
15 Project.

16 And also, we had an excellent visit  
17 with the occupational medicine department at  
18 Los Alamos, which is something, actually, the  
19 Board hasn't done on previous tours. I thought  
20 that was useful. So thank you, Greg.

21 Let's do introductions, and then  
22 we'll quickly review the agenda. So my name is

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1 Steven Markowitz. I'm an occupational medicine  
2 physician, epidemiologist, from City University  
3 of New York, and since 1997 have been running  
4 the former worker program, medical screening  
5 program for Department of Energy workers, now  
6 at 12 sites throughout the complex. Mark.

7 MEMBER CATLIN: Hi, my name is Mark  
8 Catlin. I'm a retired industrial hygienist. I  
9 spent many years working with different  
10 organizations at different DOE sites, and happy  
11 to be on the Board.

12 MEMBER VAN DYKE: Is that -- oh,  
13 there we go. It was already on. Good morning.  
14 My name is Mike Van Dyke. I'm an associate  
15 professor and industrial hygienist at the  
16 Colorado School of Public Health. I've spent  
17 many years doing research and working on  
18 several sites, mostly around beryllium  
19 exposure.

20 MEMBER CLOEREN: I'm -- I'm going to  
21 go through the same thing. You're hearing me?  
22 I'm Marianne Cloeren. I'm an occupational

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1 medicine physician and associate professor at  
2 the University of Maryland School of Medicine.  
3 I have some background with federal  
4 compensation programs, and I guess this is my  
5 second year on the Board. Happy to be here.

6 MEMBER DOMINA: Good morning. My  
7 name is Kirk Domina. I'm a retired Hanford  
8 worker. I was reactor operations, nuclear  
9 chemical operator, and the employee health  
10 advocate for the bargaining agent. I was at  
11 Hanford for 38 years.

12 MEMBER MIKULSKI: I'm an  
13 occupational epidemiologist with the University  
14 of Iowa, Occupational and Environmental Health.  
15 I direct the former worker program for the  
16 former DOE workers from the State of Iowa.

17 MEMBER SPLETT: I'm Gail Splett.  
18 I've retired from the Department of Energy at  
19 the Hanford Site after 45 years. In that time,  
20 I served as a Freedom of Information Privacy  
21 Act Officer, technical information officer,  
22 litigation manager, senior records official,

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1 and the EEOICPA program manager.

2 MEMBER BOWMAN: Hello, my name is  
3 Aaron Bowman. I'm a professor of toxicology at  
4 Purdue University. I'm in my second term on  
5 the Board.

6 MEMBER VLAHOVICH: Good morning, my  
7 name is Kevin Vlahovich. I'm an occupational  
8 medicine physician at the University of New  
9 Mexico.

10 MEMBER KEY: Good morning. I'm Jim  
11 Key, a 49 year plus employee at the Paducah,  
12 Kentucky Gaseous Diffusion Uranium Enrichment  
13 Facility. Having been on ground zero at the  
14 start and inception of this program, providing  
15 congressional testimony, and lobbying those in  
16 congress at the time for its passage, I look  
17 forward to the interactions of the Board  
18 members today, their insight, and how we can  
19 continue to streamline this convoluted program,  
20 correct the inaccuracies within it, and supply  
21 those claimants with the intent of Congress at  
22 its passage.

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1 I would also like to point out to  
2 you today, or inform you, this is the  
3 anniversary of Bill -- former Department of  
4 Energy Secretary Bill Richardson's birthday.  
5 As you may know, he passed away a couple of  
6 weeks -- months ago and was very instrumental  
7 in providing the FOIA documents that created  
8 this program. The help of him, along with Dr.  
9 David Michaels and others, we wouldn't be here  
10 today if it wasn't for him. So I just wanted  
11 to bring that to your attention.

12 CHAIR MARKOWITZ: Thank you. Dr.  
13 Friedman-Jimenez.

14 MEMBER FRIEDMAN-JIMENEZ: Good  
15 morning. I'm George Friedman-Jimenez. I'm an  
16 occupational medicine physician and  
17 epidemiologist at Bellevue Hospital, New York  
18 University School of Medicine Occupational  
19 Medicine Clinic, and this is my third cycle on  
20 the Board.

21 CHAIR MARKOWITZ: Okay, thank you.  
22 Could we -- we have a mic for members of the

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1 audience. If you could introduce yourselves,  
2 that'd be great.

3 MS. CALABAZA: Hello. Sophia  
4 Calabaza. I'm from the EEOICPA program at the  
5 Los Alamos Field Office.

6 MS. TAYLOR: Hi, good morning. My  
7 name is Tonya Taylor. I am a policy analyst  
8 with the ombudsman's office for the EEOICPA.

9 MS. FALLON: Good morning. My name  
10 is Amanda Fallon. I'm the ombudsman for the  
11 Energy Employees Occupational Illness  
12 Compensation Program.

13 MS. GRIEGO-KELLEHER: Good morning.  
14 I am Regina Griego-Kelleher, and I am the  
15 EEOICPA program manager for the U.S. Department  
16 of Energy.

17 MS. JERISON: I'm Deb Jerison with  
18 the Energy Employees Claimant Assistance  
19 Project.

20 MR. GREEN: Hello. I'm Tyler Green,  
21 chief of staff for OWCP.

22 MR. MILLER: Good morning. I'm Matt

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1 Miller, field representative with Congresswoman  
2 Teresa Leger Fernandez.

3 MS. POND: Good morning. I'm Rachel  
4 Pond. I'm the director of the Energy Program  
5 of the Department of Labor.

6 CHAIR MARKOWITZ: Carrie, did you  
7 introduce yourself, Carrie?

8 MS. RHOADS: I'm Carrie Rhoads. I'm  
9 the liaison to the Board for DOL and OWCP.

10 CHAIR MARKOWITZ: Okay. And then we  
11 have Kevin Bird and his group that -- who  
12 largely prefer to remain anonymous. So okay.  
13 Thank you. Let's discuss the agenda. Of  
14 course, we remind ourselves, our role is to  
15 provide advice to the secretary of labor  
16 regarding the EEOICP program, in particular,  
17 their five areas in our charter, which we all  
18 know very well.

19 This is going to be an interesting  
20 meeting, I think, because we're going to have a  
21 lot of discussion about important topics.  
22 We're going to -- uh -- Chris Godfrey

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1 unfortunately couldn't be here. He's the  
2 director of OWCP. Or he was here, but had to  
3 leave for a family emergency. So we're not  
4 going to receive a welcome from him, but we  
5 hope that everything works out well for him.

6 And we're going to hear from Ms.  
7 Rachel Pond, an update on the program. And  
8 then we're going to get into the site exposure  
9 matrices, which is, I think, actually, probably  
10 the number one task assigned to the Board if  
11 you look at our charter. And over the -- since  
12 2016, the formation of the Board, we have  
13 recurrently discussed the site exposure  
14 matrices, but we come back in the -- to that  
15 topic in the hope of providing additional  
16 advice.

17 And then we're going to talk about  
18 our responses to some recommendations the Board  
19 made; two recommendations at our meeting six  
20 months ago to the Department, which we received  
21 responses to those recommendations, and we're  
22 going to discuss our responses to those

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1 responses.

2 Later today, we're going to discuss  
3 -- begin the discussion about the term  
4 significance and what that means in terms of  
5 how it's described in the procedure manual and  
6 how it's used, both in the industrial hygiene  
7 analyses of claims, and presumably in the  
8 medical consultant reports as well.

9 The timing on all of these topics, a  
10 little bit uncertain, because it's not clear  
11 how long discussions will last. But we'll be  
12 flexible about that. And then tomorrow, we've  
13 received a request from Department to look at  
14 some new probable human carcinogens identified  
15 by the International Agency for Research on  
16 Cancer that have been worked up by Paragon, and  
17 we've been asked to weigh in on whether those  
18 should be added to the site exposure matrices.  
19 So we'll begin a discussion of that tomorrow.

20 And then I'll get into miscellaneous  
21 topics regarding any changes in program  
22 policies and procedures, touch on new issues.

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1 We would like to, if there are public comments,  
2 we'd like to discuss them here, to the extent  
3 that they relate to our charter, and then  
4 develop a plan for work over the next six  
5 months before our next meeting.

6 So are any -- any additions or  
7 corrections or suggestions about the agenda  
8 from Board members? Okay. Great. So let me  
9 welcome Ms. Pond to the speaker's table.

10 MS. POND: Can everyone hear me  
11 okay? Welcome, everyone. Welcome, Board  
12 Members. Thank you again for all of the work  
13 that you do to help us with our program. There  
14 -- this is not a simple program, as you all  
15 know. There are a lot of nuances and  
16 interpretations that are required, and a lot of  
17 science that's still yet to be developed. So  
18 we really do appreciate the time and effort  
19 that you all put into the work of the Board and  
20 the assistance that you provide us.

21 Today I'm going to walk through just  
22 some of our updates, kind of an overview of

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1        what we've been doing, a little bit about our  
2        policies and procedures, updates to that. And  
3        I think John Vance is on the line. He may or  
4        may not jump in. But after I talk, I will be  
5        happy to take questions before our program  
6        manager for the site exposure matrices comes on  
7        the line.

8                    He was actually on his way here to  
9        be here in person with you, but the flights  
10       just did not cooperate all day long. He waited  
11       for flights, and they kept getting cancelled,  
12       and at the end of the day, he couldn't make it.  
13       So he will be here virtually.

14                    So just a little update about new  
15       claims that we've had this -- it seems like  
16       we've had a little bit of an uptick in new  
17       claims in this last year, ranging about --  
18       especially over the last couple of weeks, we've  
19       ranged about 300 new claims per week, a lot of  
20       those coming out of our New Mexico resource  
21       facility. I'm not sure what that is attributed  
22       to, but we have been able to do a lot more

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1 outreach this year, to make people known about  
2 the program. And so that might be part of it.

3 We have -- cumulative total we've  
4 paid in the last -- in 2023 was \$2.3 billion.  
5 Over half of that is -- goes to medical  
6 benefits. You know, with our elderly  
7 population and the rising cost -- and the costs  
8 of their care, a lot of it is home healthcare  
9 and medical, you know, other medical benefits,  
10 ancillary medical benefits. Home healthcare  
11 benefits continued to rise over the last  
12 several years. We've gone from about 9,000  
13 unique home healthcare payments in 2021 to  
14 12,000, over 12,000 in 2023.

15 And we -- as a result of these  
16 rising costs, and also just the rising  
17 benefits, we've really ramped up, in 2023, our  
18 medical benefits branch. We doubled the staff  
19 in that branch to handle all of the ancillary  
20 medical equipment and home healthcare requests  
21 that have been coming in. We've adjudicated  
22 over 54,000 claims for ancillary medical

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1 benefits and home healthcare.

2 We have a new unit manager in that  
3 branch. We have a -- like, a total of six  
4 supervisory medical benefits examiners, and 52  
5 medical benefits examiners now, which is a  
6 significant increase to what we had in the  
7 past.

8 And something that -- the way that  
9 the medical benefits branch works is that the  
10 claims examiners' units, which are located in  
11 the district offices, they handle all the  
12 claims that are incoming, the development  
13 steps, all the steps before adjudication. The  
14 also will handle impairment and wage loss  
15 claims for benefits that come in after.

16 But there's a -- kind of a  
17 maintenance period after a claim is accepted,  
18 where the medical benefits need to be managed,  
19 and we need to make sure we're approving  
20 benefits as they come in. So that's why we  
21 created this other branch, so they could focus  
22 on that piece of it and our claims staff could

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1 focus on the incoming, making sure we're  
2 getting decisions out the door.

3 And then we of course have our final  
4 adjudication branch, which is made up of our  
5 hearing representatives who handle the claims  
6 for after the recommended decision before a  
7 final decision.

8 We actually, you know, we have a  
9 very robust operational plan, meaning we have  
10 very tight timeframes for our claim staff to  
11 follow. It's in our operational plan, it's in  
12 the Department of Labor's agency management  
13 plan to make sure that we are moving these  
14 cases as quickly as possible while still  
15 maintaining the quality. And so one of our  
16 goals is to complete initial adjudication  
17 within 145 days 92 -- 90 percent of the time --  
18 92 percent of the time, and we met that goal  
19 last year.

20 Final decisions on certain types of  
21 cases within 30 days, 99 percent. Within 75  
22 days, again, we are at 99 percent. A lot of

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1 our final decision processing went a lot more  
2 quickly this year, partly due to the fact that  
3 we were able to hire up a little bit more, and  
4 we were able to redistribute the claims in  
5 certain ways. Our lump sum awards have been  
6 awarded within -- 99 percent within 14 days as  
7 well.

8 So that's just some of our  
9 statistics. I'll talk -- I'm going to talk  
10 just a little bit about the site exposure  
11 matrices before we bring on the project  
12 manager. But there have been 33 sent data sets  
13 updated for 33 sites in 2023. Department of  
14 Labor assumes sponsorship for Paragon's --  
15 that's the contractor's name -- security  
16 clearances from DOE.

17 The appearance of silicosis  
18 diseases, some were updated to better support  
19 DOL procedures. So it now is silicosis acute,  
20 silicosis complicated, and silicosis simple.  
21 And their alias is combined under the same  
22 disease name, silicosis. The public internet

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1 accessible site was updated on June 13th, 2023,  
2 and the next update is scheduled to occur on  
3 November 16th, 2023, which is today, I believe.

4 Fourteen sites changed since the  
5 last update on November 16th, 2022, including  
6 significant additions to Canoga Avenue  
7 Facility, Chupadera Mesa, Climax Uranium Mill,  
8 Connecticut aircraft Nuclear Engine Laboratory,  
9 Portsmouth Gaseous Diffusion Plant, S-50 Oak  
10 Ridge Thermal Diffusion Plant, Sacandaga  
11 Facility, Savannah River Site, and Uranium Mill  
12 and Disposal South.

13 I also just want to talk a minute  
14 about some changes that were made to our  
15 beryllium vendor coverage. We published a  
16 Federal Register notice on September 14th,  
17 2023, and we added a beryllium mill in Delta,  
18 Utah as a covered beryllium vendor facility.  
19 We extended coverage at beryllium mill in  
20 Delta, Utah, beryllium mine at Topaz-Spor  
21 Mountain in Utah, and Shoemaker's plant,  
22 Pennsylvania.

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1                   This was -- basically has to do with  
2                   the definition of Brush-Wellman, which in the  
3                   site -- in the statute itself, it just says  
4                   Brush-Wellman Incorporated, and including  
5                   predecessors of such entities. So we had some  
6                   questions arise as to what that actually means  
7                   in the last year.

8                   And so we've clarified that by  
9                   adding these particular facilities. Brush  
10                  beryllium -- and we've identified these as  
11                  Brush Beryllium Company, 1969 to 1971; Brush-  
12                  Wellman Incorporated, 1971 to January 23rd,  
13                  2001; Brush Resources Incorporated, January  
14                  23rd, 2001, to March 8, 2011; and Materion  
15                  Natural Resources Incorporated, March 8, 2011,  
16                  to the present.

17                  And was the biggest, I think, one  
18                  that kind of impacted these other beryllium  
19                  vendors that we've accepted, and will impact  
20                  future ones if we determine that they're part  
21                  of this Materion Natural Resources.

22                  We've also made some updates with

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1 regard to our IT, our forms initiatives. There  
2 is a medical form called the 957 medical travel  
3 refund. This is basically for individuals who  
4 travel for medical appointments and that sort  
5 of thing. And they've been able to file this  
6 form manually for years, that's now electronic.

7 And this'll be followed by the  
8 addition of the EN-10 and EN-11B forms for  
9 impairment and wage loss, meaning people will  
10 be able to file those now electronically, and  
11 not just through the mail.

12 We are also this year in the process  
13 of developing a new consequential illness form.  
14 This is something that had been suggested by  
15 the ombudsman office for DOL. It's also some -  
16 - from surveys we've received, public outcry  
17 about differentiating between an initial  
18 condition that has been filed and a new  
19 condition that is a result of that condition.  
20 And so that, I think, will be a welcome  
21 addition to our forms process, and will be  
22 coming out this year.

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1           We are also working to add more  
2           single sign on functionality for our systems,  
3           which really doesn't impact the public or you  
4           guys, but it just means it'll be a little bit  
5           easier for our staff to sign into various  
6           systems, ECS, SEM, OIS, that sort of thing.

7           And we're also looking to -- we're  
8           working for the Office of Worker's Compensation  
9           Programs and their administrative officer to  
10          change the provider enrollment form, just  
11          because we've found that a lot of the providers  
12          say that it's complicated, it's over -- it's  
13          excessive.

14          So we're trying to -- this is not  
15          our form for energy, you know, like, ourselves.  
16          But it is an OWCP form, so based on the  
17          feedback we've received from various surveys  
18          and from providers, we are going to try and  
19          simplify that form, make it a little bit easier  
20          to understand. Again, that's something that  
21          we're working on this year.

22          We're also going to continue to do

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1 more outreach to the providers to help them  
2 understand the process, and to make sure that,  
3 you know, they're aware of the benefits that we  
4 do provide, and make it as simple as possible  
5 for them to understand so that we can get  
6 people to enroll in our program, doctors. As  
7 you know, there's a difficulty for claimants  
8 sometimes to find doctors who are willing to  
9 work with us. So we're going to continue to  
10 try to reach out to them.

11 As -- in terms of outreach, we were  
12 fortunate enough in 2023 to be able to go out  
13 and talk to people in person, and that was  
14 something that, you know, the pandemic had  
15 prevented us from being able to do. So in  
16 2023, we held nine joint outreach task force  
17 group town hall events, which is the events  
18 that we have with DOE, Department of Justice,  
19 and NIOSH. And that brought in about -- over  
20 1,300 stakeholders.

21 In 2024, we plan to hold four joint  
22 events with the joint outreach task force

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1 group. Those will include presentations from  
2 the various agencies, followed by Q&A, which is  
3 the way it typically is.

4 And then as a part of a broader  
5 strategy of targeted outreach, we're going to  
6 continue to reach out to underserved  
7 communities, locations identified through  
8 research we've done with the census bureau as  
9 having high populations of underserved  
10 communities. And we're going to prioritize  
11 those.

12 We also did, in fiscal year 2023,  
13 added two remote Navajo speaking caseworker  
14 positions to our resource centers as a part of  
15 our targeted outreach plan. They've -- they  
16 went to some of the -- they're going to  
17 continue to do outreach, and they can help us  
18 do translations when we do go out to the Navajo  
19 regions. And I think it's going to be a really  
20 good, big benefit to us in terms of reaching  
21 out to that community.

22 We're also -- in this fiscal year,

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1 we're going to be hosting smaller in-person  
2 outreach events throughout '24. This'll  
3 include our staff, research center staff,  
4 who'll present information to provide  
5 assistance to stakeholders. We're going to  
6 work with the JOTG on some of those events, but  
7 then we're all going to kind of try to find  
8 areas where we haven't been, which is always a  
9 challenge, continue to work with Department of  
10 Energy, with their lists that they have of  
11 former workers, to reach out to these areas.  
12 And we're going to come up with a calendar in  
13 the coming months to determine exactly where  
14 we're going to be.

15 We're also going to continue to  
16 sponsor webinars. We -- during the pandemic,  
17 we started to do webinars, since we couldn't do  
18 outreach to the public. And these webinars are  
19 basically people who've -- can subscribe online  
20 to get emails from us about policy or various  
21 other topics. We also publicize them.

22 But they're to count -- they're to

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1 provide information to anybody who's interested  
2 on medical benefits, survivorship, covered  
3 employment, impairment, wage loss, our FAB  
4 operations, various tools and resources we have  
5 available, and that sort of thing.

6 We also continue to do -- in the  
7 last couple of years, we've started a very  
8 robust customer experience program. We have a  
9 series of staff dedicated to this, and we do  
10 surveys throughout the year, which we'll send  
11 out to our claimant population. Sometimes  
12 we'll send out after a certain type of  
13 development was set out, or we'll send it out  
14 after they've received a certain type of  
15 medical care, or an impairment, or wage loss,  
16 to ask them how it went, what we can do better.

17 And we've really been able to get a  
18 lot of information out of these in terms of  
19 what we can do to improve, how we can -- you  
20 know, where we can target our resources to make  
21 the lives of the claimants and other  
22 stakeholders better. We're going to continue

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1 to do that in fiscal year '24.

2 We're also going to be updating our  
3 website to be more customer friendly. You  
4 know, some people say that it's hard to  
5 navigate our website, they don't know where to  
6 find things. So we're going to continue to try  
7 to make that better. And we're continuing to  
8 do what we call journey maps, which kind of  
9 gives you an idea of where -- how the claim  
10 process goes throughout the system. We're  
11 going to do another one of those on  
12 consequential illness claims in '24.

13 We also have a very robust quality  
14 control plan. We have an entire unit devoted  
15 to quality control. They review various types  
16 of decisions throughout the year, meaning they  
17 will look at the FAB decisions, our final  
18 adjudication branch decisions, medical benefits  
19 decisions, and claims examiners decisions, to  
20 determine accuracy, the quality of the case,  
21 the decisions that are being written and the  
22 development letters that are being written.

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1           And in addition to that, our -- all  
2           of our supervisors throughout the country do a  
3           very robust sampling, meaning every month, they  
4           review at least three cases a month, per CE, to  
5           see the quality of the work. It will, at the  
6           end of the day, impact their performance  
7           evaluations.

8           And we've continued our contract  
9           medical consultants and IH reviews. Those  
10          reviews encompass whether or not the contractor  
11          is adhering to the standards in the contract,  
12          but also whether or not our claims staff are  
13          referring claims in such a manner that it's  
14          understandable to the IH's or the CMC's who are  
15          receiving the request for information.

16          I'll go into a little bit of the  
17          federal procedure manual updates that we have  
18          made. In 2023, in March, we included guidance  
19          about references and links to all relevant  
20          former worker program websites. The part B  
21          silicosis, employment, and exposure criteria  
22          update for Nevada Test Site, industrial hygiene

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1 exposure reporting language modification.

2 New chronic silicosis causal  
3 presumptions under part E, employment  
4 development requirements, to include cross-  
5 reference of DOE, covered facility -- they're -  
6 - I'm sorry. It's basically the -- how to  
7 cross-reference the covered facility database  
8 with this employee pathways overview document,  
9 which is a document we have for our claims  
10 staff that kind of goes into some detail about  
11 the various facilities and helps them to  
12 adjudicate their claims.

13 And then we are releasing, probably  
14 the end of this week, the latest procedure  
15 manual update. And that covers organ  
16 transplants as an accepted consequential  
17 condition. Claimant's eligibility for an  
18 impairment award not extinguished awaiting  
19 transplant. So it has to do with the  
20 transplants and their impairment awards.

21 The procedure for handling claimant  
22 delays and scheduling impairment ratings, so

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1 we've found that for impairment ratings,  
2 claimants often times can't get a doctor very  
3 quickly who are willing to do these. So  
4 instead of just holding that case open, we're  
5 going to provide them with some options and  
6 tell them if they want to delay or defer that  
7 impairment instead of us denying it, they'll be  
8 allowed to do that for up to a period of a  
9 year. So that's in there.

10 There's some information about  
11 directed medical examinations, and we're also,  
12 you know, making sure that any impacted  
13 providers are provided copies of all decisions  
14 related to medical benefits that are relevant  
15 for that physician to have.

16 And then there's some guidance about  
17 the necessary -- where it's necessary to have a  
18 raised stamp for certain legal documents, and  
19 some follow-up actions for EN-20 forms, which  
20 is our payment forms, and how to make sure that  
21 those are getting returned. We've found that  
22 there have been a number of EN-20 forms, people

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1 who have not returned their payment forms over  
2 periods of time.

3 And we've -- you know, want to make  
4 sure we're following through with those people  
5 to see -- make sure they understood that it's a  
6 payment form, that they -- if they return it,  
7 they will get money. I mean, in some cases,  
8 people don't necessarily want to complete that  
9 form because they have other conflicts like  
10 state worker's comp or tort.

11 But for the most part, you know,  
12 we've been seeing -- we've found that there are  
13 people that maybe just haven't been aware. So  
14 we're going to make sure that they're aware  
15 that that form we sent out is their payment  
16 form, to return it and they will get their  
17 payment.

18 We are also still working on the --  
19 the Board has asked for access to our case  
20 files electronically, and we'll -- we are  
21 still, I think, in conversations with you guys  
22 about how to do that, how to make that happen,

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1 and what it would look like. It would -- there  
2 is a ECOMP system that can get you through into  
3 our system in a way that would make it maybe  
4 easier to do overall. So we're still looking  
5 at that issue.

6 John, did you want to elaborate on  
7 anything that I said on the procedure manual  
8 updates?

9 MR. VANCE: The only thing that I  
10 would add is just on the comment on the  
11 beryllium vendor register notice, that was  
12 actually a Department of Energy publication.  
13 And that was something that we had worked with  
14 cooperatively with the Department of Energy to  
15 ensure that we had resolved a question of  
16 coverage for those beryllium vendor sites.

17 And I'd also like to add that for  
18 those affected cases, we have gone back to  
19 reevaluate cases that are now going to be  
20 getting coverage because of the changes, those  
21 beryllium vendor changes to the sites.

22 This is also something that we are

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1 going, with regard to the presumptive standards  
2 that Rachel had mentioned, with the hearing  
3 loss and the silicosis, we're wrapping up our  
4 reevaluation of all of the potentially affected  
5 cases.

6 And we did that as a program to make  
7 sure that any change to those presumptions for  
8 the silicosis and the Nevada Test Site, and our  
9 hearing loss changes would also be reevaluated  
10 by the program. And I think we're wrapping  
11 that up. It's been a lot of cases looked at  
12 for the hearing loss we've reviewed. And  
13 that's all I had to add, Rachel.

14 MS. POND: Thank you. Questions?

15 CHAIR MARKOWITZ: Any Board members  
16 have questions? Go ahead, Dr. Cloeren.

17 MEMBER CLOEREN: Hi, Marianne  
18 Cloeren from the University of Maryland. I  
19 wanted to follow up on something you said. I  
20 wanted to make sure I understood it. The  
21 impairment ratings, the claimant is responsible  
22 for obtaining their own impairment rating exam?

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1 Is there not an option to get a referral  
2 through the consultant network?

3 MS. POND: There -- yes. The  
4 claimants have a couple of options. Sometimes  
5 they want to go to their own doctor, and they  
6 know of a doctor they want to go to. And if  
7 they want -- if they choose that route,  
8 sometimes those doctors they want to go to are  
9 backed up for months. And so that's where  
10 sometimes that delay comes in.

11 We also will tell them, if you want  
12 to, at this point, have one of our contract  
13 medical consultants do this, you can. They  
14 would only have to go get a certain test,  
15 depending on the kind of, you know, impairment  
16 it is. But yeah, they do have the option, but  
17 often times they want to go with their own  
18 doctor.

19 MEMBER CLOEREN: Thanks.

20 MS. POND: Mm-hm.

21 CHAIR MARKOWITZ: Other questions?

22 Actually, I have a few questions. So 500 -- or

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1       excuse me, 300 new claims per week. That's  
2       15,000 a year. So we're 23 years into EEOICPA,  
3       we're 18 years after 2005 amendment. So that's  
4       a lot of activity.

5                   And I'm just wondering if you have a  
6       sense of what all these new claims are about.  
7       Are these previous claimants who are coming in  
8       with new conditions? Are they people whose  
9       impairment rating has changed, their health  
10      status has changed, new requests for various  
11      types of medical benefits? Any --  
12      consequential conditions. Any sense of that?

13                   MS. POND: Yes. I think that a lot  
14      of them are more new conditions that are being  
15      filed from the same claimants. I think there's  
16      -- that could either be consequential or  
17      another separate condition. A lot of it is  
18      from ongoing, current, existent claimants.

19                   That said, it's hard to say, you  
20      know, where that trend's going to go. And we  
21      still are seeing new people, new claimants,  
22      just not as many. I think a lot of this is

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1 from recurring claimants.

2 CHAIR MARKOWITZ: And since we're  
3 here in New Mexico, and it seems to be a lot of  
4 new claims coming out of New Mexico, do you  
5 have any sense of what that's about?

6 MS. POND: Maybe just the outreach  
7 that we've been doing in that area. I mean, we  
8 did come out this direction last year and did  
9 some robust outreach to the Navajo area, and  
10 we've been doing some targeted outreach that  
11 way. But that's the only thing I can really  
12 say that I would be aware of that is moving it  
13 forward or making these cases more robust.  
14 John, do you think -- can you think of  
15 anything?

16 MR. VANCE: Yeah, hello everyone. I  
17 should have introduced myself. My name is John  
18 Vance. I'm the policy branch chief, so I'm --

19 CHAIR MARKOWITZ: John --

20 MR. VANCE: -- actually, Rachel --

21 CHAIR MARKOWITZ: -- it's Steven.

22 If you'd just speak a little bit more slowly,

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1 because you're coming through at super speed.

2 MR. VANCE: Okay. Good afternoon --  
3 well, good morning, everyone. My name is John  
4 Vance. I should have introduced myself before.  
5 I am the policy branch chief.

6 My research and my inquiries into  
7 this, I think, is that you have particular  
8 representatives that are serving clients, and  
9 they are driving a lot of the work, at least  
10 from my ad hoc understanding of what's going on  
11 in New Mexico.

12 You have a couple of, or a few  
13 representatives who are just very active in  
14 submitting new claims for their clients and  
15 actually reaching out to their previously  
16 accepted claimants to have them file for  
17 additional conditions.

18 CHAIR MARKOWITZ: So are these  
19 workers from Los Alamos and Sandia here in New  
20 Mexico, or are these in part from people who  
21 have retired to New Mexico, they're from other  
22 facilities and retired here? Any sense of

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1           that?

2                       MR. VANCE:  No, no.  It just is that  
3           the resource center is the one with the intake  
4           of the claim, and so that would suggest that  
5           you're dealing with individuals that have  
6           either worked in New Mexico in either mining or  
7           Los Alamos or one of the sites approximate to  
8           New Mexico.

9                       But really don't have any clear  
10           details on the genesis of this, other than the  
11           commonality of generally this means particular  
12           authorized representatives are driving a lot of  
13           the claims.

14                      CHAIR MARKOWITZ:  So -- thanks.  Ms.  
15           Pond, you mentioned quickly about accelerated  
16           silicosis, chronic silicosis, acute silicosis.  
17           I didn't quite get what you were saying there.

18                      MS. POND:  John, do you want to go  
19           into that a little bit more?

20                      MR. VANCE:  Yeah.  I'll just keep  
21           coming back for it.  So when you -- what we did  
22           was -- we used to have, in the site exposure

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1 matrices, these different variants of silicosis  
2 listed out separately. What we did was we just  
3 consolidated them all under a health effect for  
4 chronic silicosis, and then used all of these  
5 other aliases to sort of define what chronic  
6 silicosis is.

7 So now when you go into the site  
8 exposure matrices, you should be able to see --  
9 or you'll see that chronic silicosis is listed  
10 there, and all these subsets of it are listed  
11 as aliases. It's just a method for simplifying  
12 the research that's done for those claims.

13 CHAIR MARKOWITZ: And that applies  
14 to part B and part E, right?

15 MR. VANCE: Principally, it's --

16 MS. POND: It's E.

17 MR. VANCE: -- the change that  
18 applies to the site exposure matrices, so it's  
19 going to be part E primarily. It doesn't  
20 affect how we evaluate the part B claims,  
21 because those are really rigorously set by the  
22 statutory provisions for silicosis.

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1 CHAIR MARKOWITZ: So the Board has  
2 never really focused much on consequential  
3 conditions. So these would be claims that come  
4 in for new ailments that are caused or somehow  
5 related, aggravated, contributed to by prior  
6 ailments that -- for which claims were  
7 submitted.

8 And I would imagine over time, in  
9 particular as claimants age, that consequential  
10 conditions would become more and more  
11 important. So I don't know whether this is  
12 something that the Board needs to take a closer  
13 look at or not. We've touched on it in the  
14 past.

15 The -- but if you could just explain  
16 why there was a need for a new consequential  
17 condition form, and who fills out that form,  
18 and what function it serves, that would be  
19 helpful.

20 MS. POND: Absolutely. The -- so in  
21 general, as you point out, we were getting just  
22 initial claims for new claims, new conditions,

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1 and we were adjudicating those. And then we  
2 started seeing more claims being filed that had  
3 other conditions on there, and we couldn't  
4 always distinguish between whether that was a  
5 new condition that they're saying was related  
6 to their toxic substance exposure in the  
7 workplace, or that that was related to  
8 something we had already accepted, and they  
9 were saying it's related.

10 So that distinction was kind of  
11 difficult to navigate sometimes when we'd get  
12 these new claim forms in for -- under a same  
13 claimant name. And also, people were getting a  
14 little bit confused when filing these forms.  
15 They were just like well, I don't know. Do I  
16 file for a new condition? Do I just submit a  
17 letter from my doctor saying it's related and  
18 then it's accepted?

19 And we found we do need a new claim  
20 form, for certain legal reasons, to -- for them  
21 to file for any condition that they're going to  
22 file for. So they were being told okay, well

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1 you still need to file a new claim form. And  
2 then the confusion into what are we developing  
3 for here, came into play.

4 For consequentialials, it's a lot  
5 different. The process for accepting and  
6 developing a claim for consequentialials is  
7 obviously a lot simpler, because we've already  
8 verified employment, we've already established  
9 causation for the other condition, that it's  
10 related to toxic substance exposure. And this  
11 is just a matter of having -- getting a report  
12 from a doctor linking that condition to the one  
13 that we've already accepted.

14 And so, you know, knowing right off  
15 the bat, when we get that claim in, that this  
16 is for consequential, it's going to take it  
17 down another path of review. And so making  
18 that distinction is important not only for  
19 claimants to understand, but also for our  
20 claims staff when they're getting these claims  
21 to know which direction to take it.

22 CHAIR MARKOWITZ: So I would assume

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1       that a personal physician of the claimant is  
2       providing some documentation, some rationale  
3       for why this is -- the new ailment or whatever  
4       is a consequence of the prior. So are these --  
5       do these often go the CMC for additional input,  
6       or are these usually settled at the level of  
7       the claims examiner, having had the input from  
8       the personal physician?

9               MS. POND: Typically, we don't -- a  
10       lot of these don't go to a CMC necessarily,  
11       unless there's some big question about the  
12       relationship between the condition and the one  
13       that we've already accepted. You know, if a  
14       doctor just says it's related and doesn't give  
15       us any other information about how or, you  
16       know, how it -- the nexus there, then we'll go  
17       back to the treating physician usually, and  
18       usually they can provide us more information.  
19       If they can't, then at some -- in some cases,  
20       we'll take it to a CMC to kind of help us  
21       determine that.

22               CHAIR MARKOWITZ: Mr. Key.

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1                   MEMBER KEY: Rachel, you mentioned  
2                   the outreach to the Native American. Good step  
3                   forward with that -- with adding that  
4                   translator, it's my understanding there's 20  
5                   other tribes and Pueblos who also need to be  
6                   considered with appropriate outreach and  
7                   translators of their own.

8                   MS. POND: Yeah. We are, as I said,  
9                   it's actually a focus not only of the energy  
10                  program, but we have a community of practice --  
11                  we're working with other agencies across the  
12                  government, we're working with other agencies  
13                  within Department of Labor to determine the  
14                  best way to reach out to the tribal nations  
15                  across the country in various ways of -- not  
16                  only for the EEOICPA, but for other ways to  
17                  reach out to them and to provide them with  
18                  government benefits. So thank you for that.

19                  CHAIR MARKOWITZ: So I have another  
20                  question. The reevaluation, going back and  
21                  looking at prior claims from a change in  
22                  policy, of the program, that's very

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1 interesting. That sounds very challenging and  
2 extremely useful to the claimants. And you  
3 mentioned the change in the hearing loss  
4 criteria, and also the change in silicosis.

5 So I know you're in the midst of  
6 doing that, but I would request that the Board  
7 receive the results of the reevaluation, how  
8 many people were affected, what the outcome of  
9 the relook was for -- both for hearing loss and  
10 for silicosis, because that's very interesting.

11 MS. POND: We can do that. I think  
12 that, you know, it's something we do anytime  
13 that there might be a change from a denial to  
14 an acceptance. Any time the Board makes  
15 recommendations that creates new, you know,  
16 links for us, we'll go back and look at those  
17 cases. And we do the same thing with the  
18 special exposure cohorts. So we'll definitely  
19 give you the results of that.

20 CHAIR MARKOWITZ: Okay. Any other  
21 Board comments or questions? Mr. Catlin.

22 MEMBER CATLIN: Thank you, Ms.

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1 Ponds, for the report. You mentioned a claims  
2 manager quality control program, that monthly  
3 they review a small number of claims from other  
4 claimants. Did I understand that right? If  
5 you could describe that in more detail for us.

6 MS. POND: Sure. We -- in the  
7 national office, we have a group of -- well, we  
8 have a branch called the performance -- it's  
9 the -- our performance management branch. And  
10 within that branch, there is a unit of quality  
11 assurance or quality review analysts. And in  
12 the last few years, three or four years, we've  
13 created this unit in order to do a second level  
14 of kind of review of individual claims.

15 So these reviewers are not claims  
16 examiners. They are not associated with a  
17 district office. And they will take -- every  
18 month, they take a sample of cases in each  
19 category, a sample of cases from the final  
20 adjudication branch, medical benefits units,  
21 and our claims staff. They'll look at  
22 recommended decisions, final decisions,

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1 development letters, and letter decisions that  
2 are issued.

3 And they've got a list of questions  
4 that they actually use them in our quality --  
5 we've got a database that kind of captures it  
6 all. And they'll go through a list of all the  
7 different things to look for in the development  
8 of the case, in the final decision itself. And  
9 they'll categorize each case and determine  
10 whether there were deficiencies.

11 And at the end of each -- actually,  
12 the claims staff is given an opportunity, the  
13 supervisors, to go back and look at those each  
14 month to say oh, I'm looking at this case to  
15 see if there's a problem, if we need to fix it,  
16 or if I disagree. At the end of each quarter,  
17 we get quarterly reports based on these  
18 analyses throughout the year to provide us with  
19 that kind of real time evaluation of the claims  
20 and the quality thereof.

21 We used to do what we called annual  
22 accountability reviews. So we'd get a group of

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1 staff together once a year, we'd review a  
2 sample of cases from these various categories.  
3 But there was only, like, maybe a small amount  
4 that we were looking at each year, and it only  
5 gave us a snippet in time. So we changed the  
6 process so we could actually see what's  
7 happening within the last month, within the  
8 last quarter.

9 MEMBER CATLIN: Thank you. Is that  
10 -- Dr. Markowitz, is that something we've seen?  
11 I don't -- that doesn't seem like reports that  
12 we've -- that the --

13 MS. POND: I --

14 MEMBER CATLIN: -- Board has seen.

15 CHAIR MARKOWITZ: You know, I don't  
16 know. I don't know.

17 MS. POND: I'm not sure.

18 MEMBER CATLIN: If not, is that  
19 something -- are there summaries or reports of  
20 that that we could be reviewing?

21 MS. POND: I believe so. I will --

22 MEMBER CATLIN: Okay.

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1 MS. POND: -- double check on that.

2 MEMBER CATLIN: Thank you very much.

3 CHAIR MARKOWITZ: Yeah, Dr. Cloeren.

4 MEMBER CLOEREN: I have another  
5 request, Ms. Pond. Would it be possible for us  
6 to review the questions that they're responding  
7 to? That'd --

8 MS. POND: Yes.

9 MEMBER CLOEREN: -- be helpful.  
10 Thank you.

11 CHAIR MARKOWITZ: Okay. Well thank  
12 you very much, Ms. Pond. Thank you, by the  
13 way, for coming here in person as well. And  
14 throughout our meeting, if you have additional  
15 comments or we have questions, feel free to  
16 participate. Thank you.

17 MS. POND: Absolutely. And I'll be  
18 here all day today. I am leaving tomorrow, but  
19 John will be online in the morning if you need  
20 --

21 CHAIR MARKOWITZ: Okay.

22 MS. POND: -- additional questions -

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1 -

2 CHAIR MARKOWITZ: Okay.

3 MS. POND: -- answered. Before we  
4 go on to the project manager for the SEM, I --  
5 no? Do you want me to move to that or --

6 CHAIR MARKOWITZ: No, no. I just  
7 have one comment. Dr. Friedman-Jimenez.

8 MEMBER FRIEDMAN-JIMENEZ: Yes, thank  
9 you. I want to raise an issue that has become  
10 clear to me over the last several years, which  
11 is sensorineural hearing loss. And I think  
12 this is a policy issue because we've had  
13 discussions on this in the past.

14 This is common, it's debilitating,  
15 it's preventable, it's treatable with hearing  
16 aids, which are not generally covered by  
17 medical insurance or Medicare. And it can be  
18 caused by chemical exposure to a variety of  
19 toxic substances in the SEM, as well as noise  
20 exposure, which is not in the SEM, and combined  
21 causal effect of chemicals and noise exposure,  
22 as well as other things like ototoxic drugs

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1 that are not work-related.

2 But it doesn't fit easily into  
3 either the SEM, because the SEM is qualitative;  
4 it's not quantitative. And sensorineural  
5 hearing loss is really dose-dependent. It's  
6 probably related most closely to the frequency  
7 of exposure to extremely high noise levels,  
8 peak dose, in essence. It doesn't fit easily  
9 into part B because it's not ionizing radiation  
10 and it's not consistently measured. There's no  
11 individual dosimetry conducted.

12 So in reviewing the SEM for the  
13 chemical causes of hearing loss, which we did  
14 several years ago, it became clear to me that  
15 there were many people likely that had noise-  
16 induced hearing loss, or hearing loss due to  
17 the combined effects of noise and toxic  
18 substances.

19 So my question is, is there a way  
20 that this issue can be revisited? I understand  
21 that it's a legislative issue. It sort of  
22 falls between the cracks of part B and part E.

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1 But I think that there are a lot of people that  
2 could be helped if noise-induced hearing loss  
3 combined with chemically induced hearing loss  
4 were incorporated into the program and people  
5 could at least get their hearing aids paid for.

6 It is debilitating, and hearing loss  
7 has been associated with cognitive loss.  
8 Whether it's causal or consequential isn't  
9 completely clear. But that's my question. Is  
10 there a way that we can revisit this, that the  
11 Board can suggest that this issue be raised to  
12 a level that it'd be discussed, and this be  
13 addressed by the occupational worker's comp  
14 program?

15 MS. POND: So I -- noise -- my  
16 understanding, in working with our lawyers,  
17 noise by itself is not something that's going  
18 to be covered under the statute the way it's  
19 written right now. But we do consider solvents  
20 and noise exposure together already in our  
21 policy and procedure.

22 And, you know, we've looked at this

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1 over the years several times, and it's -- we do  
2 have a pretty specific way of evaluating it,  
3 based on numbers of years, based on the  
4 research we've done, based on, in fact, some of  
5 your input, the Board's input, we've changed  
6 that definition over the years.

7 But we are -- our hands are tied at  
8 a certain point when it comes to just noise,  
9 and we would have to have a combined with toxic  
10 substance exposure, solvents exposure with the  
11 noise. But, you know, we're always open to  
12 additional information or additional guidance  
13 that the Board may provide us on this issue.

14 MEMBER FRIEDMAN-JIMENEZ: So that  
15 raises the question, if someone did have purely  
16 noise-induced hearing loss, and they were a  
17 member of this program, what could they do?  
18 Could they file for worker's comp through their  
19 state where they were working, or is that  
20 precluded by their being in the OWCP? What  
21 would be their options to get some relief, and  
22 maybe get their hearing aids paid for, for

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1 example, if it's not part of the EEOICPA  
2 program?

3 MS. POND: There are other options.  
4 I mean if -- just because they file for us, if  
5 we deny it, they can go to their state, they  
6 can go to their company, file for, you know,  
7 state worker's compensation, tort claims. If  
8 we do accept -- if we do end up accepting  
9 hearing loss, sensorineural hearing loss, and  
10 it is the combined, we will pay for their  
11 hearing aids.

12 But yeah, they're not precluded from  
13 filing in other areas. It's just there might  
14 be some offset if there's a dual benefit there.

15 CHAIR MARKOWITZ: This is Steven --

16 MEMBER FRIEDMAN-JIMENEZ: All right.  
17 So there's really no other additional action  
18 that can be taken because it's at the  
19 legislative level, and we're not prepared to go  
20 to that level. That's essentially the  
21 response?

22 MS. POND: I can't make those

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1 suggestions at that level.

2 MEMBER FRIEDMAN-JIMENEZ: Okay. All  
3 right. I understand. Thank you.

4 MS. POND: Mm-hm.

5 CHAIR MARKOWITZ: This is Steven  
6 Markowitz. I just want to -- in 2017, the  
7 Board actually made a recommendation to the  
8 program regarding noise and solvent-related  
9 hearing loss. At that time, the requirement in  
10 the procedure manual was 10 consecutive years  
11 in a -- one or more particular list of  
12 occupations prior to 1990.

13 And we recommended that actually the  
14 number of years be reduced from 10 to 7, and  
15 also that the -- it not necessarily be  
16 consecutive, because it's cumulative without  
17 necessarily being consecutive. And I think we  
18 believed that the 1990 time -- date in  
19 particular seemed arbitrary.

20 I think -- I'm not -- I think our  
21 recommendation was largely not accepted, but  
22 there has been evolution in the program since

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1 that time. So I think, for instance, the list  
2 of accepted occupations has been either  
3 broadened or there's been the provision that if  
4 the claimant could demonstrate that their job  
5 title was the equivalent of one or more of  
6 those on that list, in terms of noise and  
7 solvent exposure, that they would be eligible.  
8 And I think that the 1990 date has been also  
9 eliminated.

10 MS. POND: I believe so.

11 CHAIR MARKOWITZ: So I would say  
12 that the program's slowly coming our way.  
13 Having said that, I think we could revisit  
14 this. Because the issue of 10 consecutive  
15 years, again, still seems arbitrary to me. And  
16 then the question of what the minimum number of  
17 years should be. Should it be 10 or should it  
18 be less than 10?

19 So I would think this is fair game  
20 for the Board to relook at. Comments? Other  
21 Board members? Dr. Cloeren.

22 MEMBER CLOEREN: Yeah, I totally

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1 agree. I mean, I gave a webinar on this topic  
2 about a week ago and was able to look at some  
3 of the just kind of changes in research. And I  
4 know our recommendations need to be evidence-  
5 based, and I think there may be different  
6 evidence at this point that's worth taking a  
7 look at that might help support changes in some  
8 things. Maybe the list of jobs, maybe the  
9 timing. Is that me?

10 MEMBER SPLETT: Gail Splett. The  
11 other concern that I had, I did enjoy Dr.  
12 Cloeren's webinar very much, was the term  
13 consecutive years. On -- at least on the  
14 Hanford Site, a lot of our electricians, for  
15 example, are subcontractors. They're onsite,  
16 they're offsite, they're onsite, they're  
17 offsite. And what did that mean, absolutely  
18 consecutive? Is it 10 years combined, or does  
19 it truly need to be consecutive?

20 CHAIR MARKOWITZ: Well -- Steve  
21 Markowitz. I interpret the word consecutive to  
22 mean consecutive. But that's something we

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1 should look at again. Mr. Key.

2 MEMBER KEY: Yeah, I'm Jim Key.

3 Although changes have been made based upon the  
4 Board's suggestion, we are still seeing  
5 inconsistent interpretation of the new hearing  
6 loss guidelines. The CE's are not following  
7 the new hearing loss 7.0.

8 CHAIR MARKOWITZ: Dr. Bowman.

9 MEMBER BOWMAN: Yeah. This is --  
10 thank you, Steven. I just want to second what  
11 Marianne said, and think given the amount of  
12 time passed, it definitely would be worthwhile  
13 looking at new evidence in the literature, and  
14 looking at that, I'd be happy to be involved in  
15 something like that.

16 CHAIR MARKOWITZ: You know actually,  
17 sir, while we're volunteering for this, I know  
18 that Dr. Friedman-Jimenez has an abiding  
19 interest in this topic. So I'm sure he's --  
20 would be willing to participate, Dr. Bowman. I  
21 would as well. I think I was part of that  
22 recommendation in 2017. Anyway, if other Board

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1 members -- you don't have to now, but if you  
2 decide you want to volunteer, you would be  
3 welcome.

4 Other comments or questions? So let  
5 me again thank Ms. Pond. Actually, welcome,  
6 additional people who have come into the room  
7 since we started. In particular, Mr. Greg  
8 Lewis from the Department of Energy. He's head  
9 of the unit that deals with EEOICPA information  
10 issues, and also the former worker screening  
11 program.

12 And Greg, before I -- in your  
13 absence, I thanked you for the tour --  
14 arranging for our tour yesterday. It was a  
15 very informative historian, and a great visit  
16 to the occupational medicine program, so  
17 thanks.

18 Okay. Should we move on?

19 MS. POND: Sorry, yes. Before we  
20 introduce the program manager for the site  
21 exposure matrices, I think Ryan was going to  
22 say a few words. And then I want to answer one

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1 of the questions on this before we go to him,  
2 because it was really directed to us. So go  
3 ahead, Ryan.

4 MR. JANSEN: Yeah. Thanks, Rachel.  
5 I just wanted to briefly outline the structure  
6 for this session. So the program manager for  
7 Paragon is here to provide responses to the  
8 written questions previously submitted by the  
9 Board. And the Board can certainly ask follow-  
10 up questions of the program manger as necessary  
11 to clarify any of his responses.

12 However, if the Board has new  
13 questions on new topics, the Board will be able  
14 to submit those questions in writing after the  
15 meeting and receive those responses at a later  
16 date. Thank you.

17 MS. POND: Thank you, Ryan. I also  
18 just wanted to mention, and Dr. Markowitz,  
19 maybe we can discuss this, but he had suggested  
20 that maybe we could -- they could do a demo to  
21 small group of Board members, if you want to  
22 take that into consideration, of the SEM

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1       itself, and kind of walk through some of that  
2       at a future date, maybe in one of your  
3       subcommittees or something like that, just to  
4       kind of give them a better understanding of the  
5       ins and outs of it.

6               I know you've got some demos, but it  
7       might be something you want to talk about and  
8       consider in -- just because in a smaller group  
9       and not a public meeting, if that's possible,  
10      that might be helpful to --

11              CHAIR MARKOWITZ: Sure. That'd be  
12      great. The offer is accepted.

13              MS. POND: Okay, great. The first -  
14      - before we move on, the first question just  
15      asked about the status of -- you guys had asked  
16      for certain documents, like the contract for  
17      Paragon. We are still awaiting information  
18      from our procurement people at Department of  
19      Labor.

20              We did follow up with them just  
21      before I got here. I will follow up with them  
22      again on Friday when I return to the -- to D.C.

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1 to ask them about this and elevate it as  
2 necessary. I apologize for the length of time  
3 it's taken to get you an answer on that, and  
4 hope to get you something very shortly about  
5 what we can and cannot give you regarding that  
6 contract. Ms. Splett?

7 MEMBER SPLETT: Gail Splett. One of  
8 the things that we talked about this morning is  
9 one of the things we're not interested in in a  
10 contract are any financial arrangements --

11 MS. POND: Okay.

12 MEMBER SPLETT: -- how the  
13 contractor's paid, how they're paid, what  
14 they're paid is not really of interest to us.

15 MS. POND: Okay. So we can make a  
16 note of that. Okay. So without further ado,  
17 as I indicated, unfortunately he couldn't be  
18 here in person, but is on the -- online. Mr.  
19 Pete Turcic is the program manager for the site  
20 exposure matrices.

21 He has extensive experience with  
22 this program. As many of you may know, he used

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1 to be the director of the energy program at  
2 Department of Labor before me. He also has  
3 extensive scientific experience over his long  
4 career at various agencies. And I will turn it  
5 over to him. Pete.

6 MR. TURCIC: Thank you, Rachel. Can  
7 you hear me?

8 MS. POND: Yes.

9 MR. TURCIC: Okay. Thank you. Like  
10 Rachel said, I really -- I'm sorry that I  
11 couldn't, you know, make it out there to be  
12 with you in person. It'd be a lot simpler.  
13 But United Airlines just wouldn't cooperate  
14 yesterday.

15 I guess I'll just go through these  
16 additional questions. The second one regarding  
17 the -- that SEM includes 132 substances with  
18 152 disease links not in HAZMAT. And the Board  
19 is requesting that this -- for the list of  
20 those associations.

21 Our chemical manager put together a  
22 list for me. I just received it. Basically,

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1 it gives you an idea of what those substances  
2 are and the links. A hundred eleven substances  
3 are tied to Parkinsonism in SEM, which is not  
4 in HAZMAT. HAZMAT does not recognize  
5 Parkinsonism, and so there were 111 substances  
6 that are tied to that disease.

7 The remaining of those 132  
8 substances, there was 21 substances tied to 41  
9 diseases that are not in HAZMAT, and those are  
10 all based on the Board's recommendation to  
11 include the IR2A links. So that's -- that is  
12 the genesis of those substances that -- and  
13 disease links that are in SEM.

14 And I just got that, as I said, I  
15 just got that list. I'll be submitting it to  
16 DOL, and then, you know, for response, you  
17 know, back to the Board. Any other questions  
18 on those differences?

19 CHAIR MARKOWITZ: Dr. Bowman.

20 MEMBER BOWMAN: Yes. This is Aaron  
21 Bowman. I just -- I obviously will wait until  
22 we get the actual list. But of the 111 that

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1 are tied to Parkinsonism, which seems very  
2 reasonable, there are actually a large number  
3 of chemicals tied to Parkinsonism, could you  
4 talk to me about sort of the timing of when  
5 those got added and the rationale, just like  
6 you just did for the IR related --

7 MR. TURCIC: Yeah. The rationale  
8 for that was based on, as you know, HAZMAT does  
9 not recognize Parkinsonism. And at DOL's  
10 direction, Parkinsonism was going to be  
11 recognized and linked. And so we went through  
12 and tied 111 substances to Parkinsonism.

13 MS. POND: And this is Rachel. Just  
14 to clarify, our toxicologist did some research  
15 on that, and we had various -- and that was  
16 part of the reason.

17 MR. TURCIC: Yeah.

18 MEMBER BOWMAN: And just sort of the  
19 timing on that.

20 MS. POND: We'd have to go back and  
21 look at the exact time when those were added.  
22 I don't have that off the top of my head.

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1 Pete, you don't either, I'm assuming.

2 MR. TURCIC: No, I don't know  
3 exactly. It was quite a while ago.

4 MS. POND: Yeah. It's been a while.

5 MEMBER BOWMAN: That's fine.

6 CHAIR MARKOWITZ: Steve Markowitz.  
7 Excuse me. Actually, I think I remember. The  
8 Board made a recommendation around Parkinson's  
9 disease --

10 MS. POND: Yes.

11 CHAIR MARKOWITZ: And also the  
12 second set that Mr. Turcic mentioned, the IR2A  
13 carcinogens. That was June 2020. Dr. Mikulski  
14 led the group that looked at Parkinson's  
15 disease within the Board, he made a certain  
16 recommendation, and that was accepted by the  
17 program.

18 And so thereafter it became  
19 operational, they had to determine which  
20 particular agents would be covered. And  
21 actually, I don't think we've ever seen that  
22 list. So we welcome seeing that list. So

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1 that's the genesis. It would have occurred --  
2 would have happened over the past three years.

3 MR. TURCIC: Okay. As I said, I'm --  
4 - I just got the list, and I'll be, you know,  
5 submitting that to DOL.

6 MS. POND: So the --

7 MR. TURCIC: Any other questions?

8 MS. POND: Sorry. This is Rachel.  
9 Before Pete goes on, the next -- number three  
10 question you guys had was that you indicated  
11 that the SEM links for the four closure sites  
12 didn't work. And, you know, we did go back in  
13 and basically tried to reenact getting to those  
14 links, and were able to successfully use the  
15 closure links for Rocky Flats and K-25.

16 Again, maybe that demonstration that  
17 we've talked about can help with that. And  
18 Pete, you can add to that if you have anything  
19 to add to that.

20 MR. TURCIC: Yes. I just wanted to  
21 add that if -- the way it is presented in the  
22 IAS, or the internet accessible SEM, is there's

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1 a -- up on the right-hand side, when you pull  
2 up the site, it'll say, you know, search a  
3 specific to the selected site, and like, for  
4 example, it'll say Oak Ridge Gaseous Diffusion  
5 Plant, and then below, in a -- in blue  
6 lettering would be, you know, to see the  
7 closure profile, and you just click on it for  
8 the closure from 1988 and beyond.

9 And then when you click on that,  
10 that brings up -- that'll bring up, in IAS,  
11 that'll bring up the closure profile for K-25,  
12 for example. And then the blue below would be  
13 -- would give a warning -- not a -- I mean an  
14 indication to return to the main Oak Ridge  
15 Gaseous Diffusion Plant profile, all pre 1988  
16 plant operations, and 1988 to 2020 basic site  
17 services. And then you click on that and it  
18 takes you back to the operational site profile.

19 That may be confusing, but it is  
20 explained in the -- if you go to the guidelines  
21 that are on the public SEM, it'll explain how  
22 you go back and forth on those.

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1 CHAIR MARKOWITZ: Okay. Thank you.

2 MR. TURCIC: On question four,  
3 seeing the change logs was useful. And for  
4 nondisclosure sites, it was unclear how SEM  
5 captures the changing nature of toxic substance  
6 exposures by job category buildings over time.

7 Here again, a demonstration would  
8 probably be the most useful. But in responding  
9 and putting together, you know, the response  
10 for that, we -- I tried to look for some  
11 examples to use as a -- to demonstrate.

12 And a very good example to show you  
13 what -- how things, you know, stay in SEM  
14 throughout the life cycle of a particular  
15 element, a good example is the Hanford B  
16 reactor. You know, it is now a National  
17 Historic Landmark at the Hanford site. But it  
18 was the world's first plutonium producing  
19 reactor created in the Manhattan Project.

20 At that building, the construction  
21 for B reactor began in 1943. And it was  
22 initially shut down at the end of 1946, but

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1 then restarted in '48 to continue to support  
2 the production of plutonium for the Cold War,  
3 and it operated until 1967.

4 As I said, the B reactor is now a  
5 museum. And in fact, the Department of Energy  
6 offers public tours at it. If you go into SEM  
7 and you look at B reactor, basically what it'll  
8 show you, that there are 44 toxic substances  
9 listed as potential exposures in building 105C,  
10 which is now listed as an alias of the B  
11 reactor museum.

12 If you look at some of those 44  
13 contaminants, they include things like carpet  
14 cleaners, floor strippers, floor waxes, and  
15 other commercial cleaning products that you  
16 would expect, you know, to see in something  
17 like the museum. But then there's also present  
18 a whole host of contaminants that you would  
19 expect to see at a operating reactor or a, you  
20 know, during the decommissioning and  
21 decontamination of the reactor building.

22 And for -- like for example, there -

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1 - the site, the work processes, activities that  
2 are listed in that include things like asbestos  
3 assessment and abatement, cleanup equipment  
4 with solvents, decontamination and deactivation  
5 commissioning, D&D activities, museum and  
6 visitor support activities, reactor operations,  
7 and bell pit operations.

8 And also, you know, some of the  
9 labor categories that are there span that whole  
10 life cycle also, asbestos worker,  
11 decontamination and decommissioning worker, D&D  
12 worker, D&D operator, laborer, operator of  
13 nuclear plant, operator of nuclear process, and  
14 health physics technician.

15 That was just one example of what is  
16 attempted, and any information that we get that  
17 we apply to a building or a work process, that  
18 stays in SEM and does not come out. And then  
19 it's just factored in in the, you know, during  
20 the adjudication process of, you know, what  
21 contaminants may be applicable to a given labor  
22 category or work process.

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1           There's many other examples. And I  
2 think, again, I think some demonstration may be  
3 well worth it to, you know, to show how things  
4 that people have specific questions about  
5 specific sites, in that we could go through and  
6 demonstrate and see what is in SEM now.

7           If we had identified a document that  
8 -- and something was added to SEM, we don't  
9 take it out when, you know, when the nature of  
10 the building changes. Any other questions on  
11 that?

12           CHAIR MARKOWITZ: This is Steve  
13 Markowitz. So under what circumstances do you  
14 remove information from the SEM?

15           MR. TURCIC: The only time we remove  
16 information is if we find information that is  
17 an obvious error. To give you an example, we  
18 recently, in the spreadsheet in the SEM  
19 display, the SEM profile for ORISE included for  
20 the labor category for the security guards,  
21 included information, the generic profile  
22 information for, you know, weapons work.

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1 Cleaning weapons, target practice, there -- a  
2 whole -- there was a whole profile or a generic  
3 profile for weapons work.

4 Well, in a SEM mailbox question, and  
5 in contact with the -- with DOE at the site, we  
6 came to find out that the guards at ORISE never  
7 carried weapons. So that was one example of,  
8 you know, substances that would be removed. We  
9 don't remove things, and anything that's taken  
10 out is, you know, is coordinated with DOL.

11 CHAIR MARKOWITZ: Other comments,  
12 questions from Board members? Mr. Key.

13 MEMBER KEY: So explain to me, if  
14 you will, how we have a SEM database for the  
15 Paducah Gaseous Diffusion Plant that had its  
16 own fluorine sale operation, and when you go to  
17 that building, fluorine is not a listed  
18 chemical under it. There's no chemical  
19 relation or chemical stated for that building  
20 at all. How is that possible?

21 MR. TURCIC: It would depend on how  
22 -- so you're saying fluorine don't show up at

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1 all in the -- or for the building or that work  
2 process?

3 MEMBER KEY: I'm sorry. I didn't  
4 understand your statement.

5 MR. TURCIC: If you look under the  
6 work process, would fluorine show up for that  
7 labor category?

8 MEMBER KEY: No, it does not.

9 MR. TURCIC: I would have to look  
10 into that. And which building is that?

11 CHAIR MARKOWITZ: Are there more  
12 comments, questions?

13 MR. TURCIC: Which building was it  
14 in Paducah?

15 MEMBER KEY: It was the C410, K, and  
16 D building.

17 MR. TURCIC: C4 --

18 MEMBER KEY: C410 -- 4, 1, zero, D,  
19 and K building.

20 MR. TURCIC: We'll look into that  
21 and provide a response to, you know, to DOL  
22 that they can pass it on to the Board, then.

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1 CHAIR MARKOWITZ: So this is Steve  
2 Markowitz. I have a question.

3 MR. TURCIC: Sure.

4 CHAIR MARKOWITZ: So I think I  
5 understand closure sites and how the SEM  
6 addresses them for -- et cetera, that --

7 MR. TURCIC: Yeah.

8 CHAIR MARKOWITZ: -- there's a  
9 description of -- there's inclusion of job  
10 titles, work processes, agents, buildings, et  
11 cetera, facilities that are applicable when the  
12 site was active, and then you can --

13 MR. TURCIC: Mm-hm.

14 CHAIR MARKOWITZ: -- delineate  
15 pretty clearly the period of time when the D&D  
16 occurred and it was closed, and what the  
17 potential exposures were during that time  
18 period with associated --

19 MR. TURCIC: Mm-hm.

20 CHAIR MARKOWITZ: -- job titles and  
21 the like. So I think I get that. I'm not sure  
22 I accessed every one, but I think I get the

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1 approach.

2 But what I still don't understand is  
3 all these sites evolve over time in terms of  
4 what they do, what their function is. They  
5 take on special projects during certain  
6 periods. And the SEM by and large doesn't  
7 contain dates. It doesn't really date when  
8 certain activities occurred. There might be  
9 closure dates --

10 MR. TURCIC: Right.

11 CHAIR MARKOWITZ: -- but generally  
12 speaking, there aren't dates. And I understand  
13 why there are not dates, because probably the  
14 underlying information didn't allow you to put  
15 in dates accurately, with confidence. So I get  
16 that.

17 But as the mission of a site, the  
18 activities, what it does evolves over the  
19 decades, I don't quite get how the SEM contains  
20 the information about how potential exposures  
21 might evolve over that period. Again, I'm not  
22 talking about closure activities. I'm talking

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1 about a site that was active, still active for  
2 decades, in a given building, and they did one  
3 thing in the '70s and something else in the  
4 '90s. Even the same job title could change in  
5 terms of the insulators work with asbestos in  
6 the '70s, and in the '90s it was fiberglass.  
7 So how does the SEM deal with that kind of  
8 evolution?

9 MR. TURCIC: It -- all of the  
10 substances, SEM is basically validating that  
11 there was some document identified that some  
12 toxic substance was potentially present. So if  
13 it was present, it stays in SEM. And SEM  
14 cannot identify -- you're absolutely right  
15 about dates. There's -- that's next to an  
16 impossibility, to identify dates.

17 As an example, you know, there are a  
18 lot of refrigerants and things like that that  
19 changed over time, and SEM contains them all.  
20 And then during the claims process is where it  
21 is worked out what is the likelihood, you know,  
22 of some contaminant.

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1           But like I'm saying, we -- if we  
2 document and validate a substance was present,  
3 it stays there. The example that I was talking  
4 about is a perfect example, is that reactor B.  
5 There's information in SEM today that covers  
6 that reactor B through the whole life cycle,  
7 when it was a reactor being constructed, when  
8 it was operating as a reactor, when it was  
9 decommissioned, and now that it's a museum.  
10 And that's the general principle that is  
11 applied to SEM.

12           Dates are -- and as you know, dates  
13 can be very misleading. For example, when a  
14 building goes into operation, that's usually  
15 the date or, you know that is in documents that  
16 something became operational. But in the DOE  
17 process, those processes were tested prior to,  
18 you know, before there was readiness reviews,  
19 things like that.

20           And so there were potential  
21 exposures, and that's why we put -- when we  
22 identify a potential exposure for a process or

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1 a building or a labor category, it goes into  
2 SEM and it remains there, again, unless we find  
3 out that there was some error.

4 CHAIR MARKOWITZ: So by the way,  
5 another example, just to probe a little here --  
6 and Mr. Key, I may need some help. But in the  
7 '70s, in Paducah, there was a period of time  
8 when they were undergoing major renovation, or  
9 some major redo of some -- yeah, okay. And so  
10 that was time -- that was a time-limited  
11 project, right? That occurred over whatever  
12 number, three, four, five years -- eight years.  
13 Okay. And that was in the '70s right, roughly?

14 And so that special process entailed  
15 -- well this is a question, actually. Would it  
16 have entailed, perhaps, different exposures  
17 than occurred otherwise, either before or after  
18 that at Paducah?

19 MEMBER KEY: Well, certainly, any  
20 exposures that occurred during that time,  
21 because they were tearing down and rebuilding a  
22 cascading enrichment cell, one per week. You

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1 had three basic labor categories. They're  
2 tearing it apart and putting it back together.

3 This is when the 40-foot converters  
4 were cut out and lifted up above the workers,  
5 taken down a crane rail, hitting lead air,  
6 thereby producing HF where you couldn't even  
7 see the crane operator operating a crane.

8 And after that Sitka Cascade  
9 Improvement Project, those exposures, you know,  
10 decreased significantly. There were still  
11 some. There was still some HF exposure and  
12 equipment leaks. But by and large, during that  
13 phase of the cascade improvement process is  
14 when you had the potential and the likelihood  
15 of the greatest exposure period, with exception  
16 to the plutonium exposure that the federal  
17 investigative DOE team came into Paducah and  
18 created EEOICPA.

19 CHAIR MARKOWITZ: Okay. So I take  
20 it then that certain exposures might have been  
21 more intense, but SEM doesn't deal with  
22 intensity of exposure.

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1 MR. TURCIC: Right.

2 CHAIR MARKOWITZ: But if there were  
3 some chemicals that were used in the eight year  
4 period that weren't used previously or  
5 thereafter, so they would be unique to that  
6 operation, that period of time at Paducah, so  
7 the question really is, then, for Mr. Turcic is  
8 so how do you deal with that in the SEM?  
9 Because Paducah operated from '53 -- yeah, '52  
10 to '20.

11 MR. TURCIC: The way we deal with  
12 that is that we're always updating and getting  
13 -- if we got documents, and I'm sure if it was  
14 a major project that they probably had  
15 documents identified -- that identified that as  
16 a process, and then that information would be  
17 in SEM.

18 And the way we deal with that on a  
19 continuing basis is when we are trying to  
20 update all these active -- the large active  
21 sites on a five to 10 year cycle, and the way  
22 we try to do that is we have a two-tier

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1 process. The initial request for documents is  
2 we'll ask for very high level documents.

3 Like we're in some reviews now that  
4 the last major review was in 2015. So our  
5 first initial document request from DOE would  
6 be high level documents, like their -- asking  
7 for their capital projects back to 2015, and  
8 asking for their industrial hygiene surveys,  
9 and other 851 required, you know, documentation  
10 back to that time. We asked for information on  
11 maps, the most current map. And then our  
12 researchers look at that information and  
13 identify things that, you know, that we may not  
14 have in SEM currently.

15 And then our -- we go with our  
16 second document request, where we get more  
17 specific, you know, input. Well, we don't have  
18 this process, so can you give us the procedures  
19 related to that, the health and safety analysis  
20 reports related to that, and so forth?

21 So we're always trying to, you know,  
22 update things. And we try to keep track of

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1 major projects that are going on in the DOE  
2 facility. And when things change, we try to,  
3 you know, to schedule an update in order to add  
4 the new facilities and things like that.

5 We've been doing that for quite a  
6 while now, and that seems to be the best way we  
7 know how of, you know, keeping up with changes  
8 at sites, because there's changes all the time.

9 CHAIR MARKOWITZ: Mr. Key.

10 MEMBER KEY: Yeah. Mr. Turcic, back  
11 to my initial question to you regarding the  
12 C410 D --

13 MR. TURCIC: Yes.

14 MEMBER KEY: -- and C410 K  
15 buildings. Fluorine is listed --

16 MR. TURCIC: Yeah.

17 MEMBER KEY: -- but when you go down  
18 to the labor category involved, it has none. I  
19 have a group of workers who most recently,  
20 within the last year and a half, were running a  
21 special project, and we will be filing their  
22 claims as a group, not as individuals. They're

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1 -- this was a specific project. They all  
2 received high exposure from fluorine, and one  
3 had to be treated in the hospital for four  
4 days.

5 So when we pull up the SEM, or when  
6 someone submits a claim and the CE pulls the  
7 SEM up and there's no labor category involved  
8 in this building location, then they're  
9 automatically denied.

10 MR. TURCIC: That's -- I would be  
11 surprised if that's the case. First of all,  
12 you've got to realize that SEM is basically a  
13 relational database. And if that -- those  
14 chemicals were tied to that labor category, it  
15 would show up as that labor category. And then  
16 if that labor category is shown working in that  
17 building, then that's how it gets tied in, you  
18 know, to tie it into that building.

19 MEMBER KEY: To my point exactly.  
20 There is no labor category listed.

21 MS. POND: Okay. This is Rachel --

22 MR. TURCIC: What do you mean

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1       there's no labor --

2                   MS. POND: This is Rachel. I just  
3 wanted to add here that, you know, the SEM  
4 isn't a decisional database. The claims  
5 examiners don't go to SEM and say this will  
6 determine whether or not a case is accepted or  
7 not. But we look at all the other evidence in  
8 the case file, any statements that are  
9 submitted, affidavits, we utilize our  
10 industrial hygienists.

11                   You know, so yes, the SEM is built  
12 as a tool to assist our claim staff in  
13 adjudicating claims, in helping them guide  
14 their -- the direction of the claim. However,  
15 they look at everything that's submitted in the  
16 case file and take that a whole. So I just  
17 wanted to make sure we're keeping that in mind  
18 when we say, you know, oh, it's not in SEM, and  
19 therefore it's going to be denied.

20                   Also, the SEM is always evolving.  
21 It's not going to be -- have everything in it  
22 from day one. That's why we're constantly

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1 updating it. As we get more information, we  
2 can submit things through the SEM mailbox and  
3 they will review those incidents, accidents,  
4 things like that.

5 So all of that can be added if we  
6 don't already have information about it. And  
7 when we're looking at an individual case, we're  
8 looking at the whole. So I just wanted to  
9 clarify that.

10 MR. TURCIC: Rachel, can I add  
11 something there? I can give you a direct --  
12 recent example that Rachel is mentioning, that  
13 in a case that was filed, a claims examiner had  
14 a question, and some of the -- a DAR request,  
15 the document access request that a claims  
16 examiner gets from DOE had information that was  
17 not in SEM.

18 So they sent a question to the SEM  
19 mailbox, and information from a medical record  
20 that was in that claim was then used to add  
21 that to SEM. And we add -- you know, you had a  
22 question -- the Board had a question about the

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1 difference between minor and major updates.  
2 Most of the minor updates are things where we  
3 get documents through the SEM mailbox, or come  
4 through the IAS, that has information not in  
5 SEM that we then update that profile to add  
6 that information.

7 CHAIR MARKOWITZ: This is Steve  
8 Markowitz. So I know you're updating the SEM  
9 all the time, but how much new information do  
10 you really get about the old processes, you  
11 know, going back to the '60s, '70s, '80s. Are  
12 you really receiving new documents regarding  
13 those -- that era in terms of updating the SEM,  
14 or is most of the update really framed around  
15 the current or recent activity, say over the  
16 past 10 years?

17 MR. TURCIC: The -- more the  
18 current, recent, over the past 10 years.  
19 However, our library has thousands of records  
20 that were received initially, and then in  
21 subsequent, you know, updates from the DOE  
22 sites. You know, we're always receiving

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1 documents from the DOE sites.

2 Again, you're right. Most of the  
3 records were -- from years back were received  
4 in the initial development of SEM, where the  
5 researchers went to the -- right to the sites  
6 and obtained records, and those are all in our  
7 -- in the library. But there's very few -- we  
8 very seldom get new records that are dealing  
9 with, you know, from years ago.

10 CHAIR MARKOWITZ: Are there  
11 comments, questions from the Board? Ms.  
12 Splett.

13 MEMBER SPLETT: Are we going to go  
14 to the original questions that we sent to  
15 Department of Labor, or just these supplemental  
16 ones?

17 CHAIR MARKOWITZ: We may go through  
18 whatever we want to go through. So if we're  
19 going to start on a series of questions, we  
20 might take our break for a few minutes and then  
21 start. Maybe that'd make some sense.

22 MS. POND: Doctor Markowitz, we have

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1 this set of questions still, which there's  
2 only, I think, four more questions on here. We  
3 can go back through those other responses. I  
4 just -- there was a lot of them, so just keep  
5 that in mind.

6 CHAIR MARKOWITZ: Right, right.

7 MS. POND: That was like 10 pages  
8 worth of questions. I'm not sure you're going  
9 to be able to go through all 10 of them --

10 CHAIR MARKOWITZ: Right.

11 MS. POND: -- today. But --

12 CHAIR MARKOWITZ: We'll try to speak  
13 quickly.

14 MS. POND: All right, thanks.

15 CHAIR MARKOWITZ: Okay. So it's  
16 quarter of 11:00, so let's take a 15 minute  
17 break, reconvene at 11:00 a.m. Thanks.

18 (Whereupon, the above-entitled  
19 matter went off the record at 10:42 a.m. and  
20 resumed at 11:01 a.m.)

21 CHAIR MARKOWITZ: Okay, let's  
22 resume. I want to remind the Board members,

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1 having not reminded you before, that when you  
2 have a comment or you want to speak, just if  
3 you could take your name board and put it  
4 vertical so I -- otherwise, I'm just looking  
5 around the room.

6 So Ms. Splett, you had some  
7 responses or questions you wanted to follow up  
8 on.

9 MEMBER SPLETT: I do. I have some  
10 questions of -- after I got those answered --

11 CHAIR MARKOWITZ: Is your mic on?

12 MEMBER SPLETT: -- whether the rest  
13 of the team wants to go through the Board --

14 CHAIR MARKOWITZ: Is your mic on?

15 MEMBER SPLETT: Yes, it is. Pardon?  
16 Okay. I do have some follow on questions, and  
17 then if the rest of the Board wants to go  
18 through the detailed questions, we certainly  
19 can.

20 But I have some kind of specific  
21 questions, one of which is, is the majority of  
22 the SEM in Excel spreadsheets or is there a

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1 relational database, SQL or ACCESS that is  
2 being utilized, or is it mainly just in Excel?

3 MR. TURCIC: No, it's a combination.  
4 The spreadsheets are Excel spreadsheets, but  
5 that's just the raw data. Then there's a huge  
6 relational database, with a lot of coding that  
7 goes into it, that -- and that's done in, I  
8 believe it's ColdFusion.

9 MEMBER SPLETT: One of the things  
10 that I was concerned about reading some of  
11 this, it talked about Paragon owning some of  
12 the data, and that was some of the concerns  
13 about releasing the spreadsheets. Is that what  
14 the ownership of records clause says with DOL  
15 and their -- contract, or is that something  
16 that you're comfortable answering right now?

17 MR. TURCIC: Our concern with the  
18 spreadsheets themselves is -- really gets to  
19 proprietary information, and also an issue, a  
20 potential classification issue.

21 MEMBER SPLETT: Okay. So if we ask  
22 for the spreadsheets that have earlier been

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1 released and published, they've been classified  
2 reviewed, so they were already released.  
3 They're not proprietary because they're already  
4 in the public domain. But I think many of us  
5 did not think to copy those at the time.

6 But if we ask for the spreadsheets  
7 for K-25 or PFP, excuse me, the Plutonium  
8 Finishing Plant, for those spreadsheets that  
9 have already been published, there should not  
10 be any classification review or concern or any  
11 proprietary concern. Is that correct?

12 MEMBER SPLETT: No, it's not, and  
13 here's why. Let me explain. What goes through  
14 classification review is the display, the SEM  
15 display. So it's a combination of the  
16 spreadsheet, plus the coding in -- the SEM hard  
17 coding.

18 One of the big concerns from a  
19 classification standpoint is the, you know, the  
20 presence of a mosaic effect. Now, what that  
21 means is that there can be several pieces of  
22 non-classified information that when put

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1 together, becomes classified.

2 DOE office of classification does  
3 not -- has not reviewed the spreadsheets  
4 themselves. They review the changes that we  
5 make and the outcome. And the important  
6 difference is that there are some issues, and  
7 that's what I explained in my -- I have to be a  
8 little careful in my -- in the response that  
9 DOL sent through, I explained that how we  
10 handle that information is all provided in a  
11 secret document, and I really can't go into  
12 details on that. But --

13 MEMBER SPLETT: So --

14 MR. TURCIC: But what --

15 MEMBER SPLETT: -- I guess my  
16 question is --

17 MR. TURCIC: But --

18 MEMBER SPLETT: -- what has shown up  
19 for the SEM, the public view, and if we asked  
20 for that historically, the public view of that  
21 SEM for a particular facility --

22 MR. TURCIC: Oh.

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1                   MEMBER SPLETT:  -- from when you  
2 first started it, can you share that with us?

3                   MR. TURCIC:  No, because we don't  
4 have them.  When it changes -- that would mean  
5 making a complete copy of every SEM version and  
6 keeping it.

7                   MEMBER SPLETT:  You don't have a  
8 record copy of all of the changes and how you  
9 publish them?

10                  MR. TURCIC:  Oh, we have a copy of  
11 all the changes that we made in the  
12 spreadsheets.  But what you're asking for is  
13 the SEM display.

14                  MEMBER SPLETT:  Correct.

15                  MR. TURCIC:  It -- the SEM -- we  
16 don't keep the complete SEM display.  It's a  
17 whole database.  That would be keeping a copy  
18 of, you know, the -- every SEM version every  
19 time there's a little change made.  We just  
20 don't keep those.

21                  MEMBER SPLETT:  I -- okay.  I guess  
22 I'm a little bit surprised that you have not

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1 maintained that. But could we do a couple of  
2 examples of things we've -- questions we'd like  
3 to ask you on the SEM, Dr. Markowitz? Is that  
4 okay, or do you have other questions you want  
5 to ask?

6 CHAIR MARKOWITZ: No, no. I don't  
7 have any questions. Go ahead. Dr. Bowman, did  
8 you want to chime in here?

9 MEMBER BOWMAN: Sorry. This is just  
10 a quick follow-up to the keeping of past  
11 versions of the display of the SEM. What is  
12 the size of the database in question here that  
13 we would be talking about being kept? Are we  
14 talking about terabytes, gigabytes, more than  
15 gigabytes?

16 MR. TURCIC: You'd have to -- I'd  
17 have to get that -- the size from, you know,  
18 our IT people. But just as an example, just  
19 the spreadsheet alone for Hanford is something  
20 like 140 or 150,000 lines of data --

21 MEMBER BOWMAN: Okay.

22 MR. TURCIC: -- and, you know, every

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1 version.

2 MEMBER BOWMAN: If you could ask the  
3 IT what the total size is, and then backup was  
4 a relatively -- you know, if it's less than a  
5 terabyte, that would not be very onerous, I  
6 wouldn't think. And that length you described  
7 would, I think, in my mind, be well less than a  
8 terabyte. Could -- would it be possible to  
9 keep those going forward?

10 MR. TURCIC: That's one spreadsheet.

11 MEMBER BOWMAN: Yeah.

12 MR. TURCIC: Multiply that by 140.

13 MEMBER BOWMAN: Sure.

14 MS. POND: I'm not sure what you're  
15 asking.

16 MR. TURCIC: I'll --

17 MS. POND: We -- this is Rachel.  
18 I'm sorry. I mean, we keep a -- we keep track  
19 of the changes. To say that every time we make  
20 a change, and we have to keep an entire new  
21 copy of the entire database, it's not really a  
22 feasible way to do it. We have all the

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1 information about what changed in the  
2 documents, and we have a record of all of that.  
3 But we revise it every six months and republish  
4 it every six months.

5 So to say oh, we're just -- instead  
6 of continuing to publish based on the database  
7 that was there and increase it, you want us to  
8 keep a picture of all these databases for the  
9 last ten or plus years so that we can go back  
10 into 2000 and, you know, six and say oh, this  
11 is what it looked like then, it's just not a  
12 feasible way -- we haven't done it that way.  
13 We do have a record to show what changed.

14 MEMBER BOWMAN: Sure. I guess I was  
15 just asking because I was -- I got the  
16 impression that the record of what changed is  
17 not accessible, that the Board can't view that  
18 because it has the proprietary information. So  
19 therefore, the only way the Board could  
20 evaluate it is the public version.

21 MS. POND: I believe that it's  
22 something that is currently under review, how

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1 we -- what we can provide to you. That's  
2 something that's currently with our  
3 procurement, as I indicated earlier.

4 MEMBER BOWMAN: Yeah. I think the  
5 Board is only interested in just trying to see  
6 the changes over time. And just if the -- if  
7 the way were talking about it is not possible,  
8 then an obvious possibility would be just to  
9 save a mirror image of the database. And data  
10 storage is really inexpensive.

11 So I don't understand the full  
12 details, but I would think data storage is  
13 super inexpensive and easy to do. So that  
14 would be another solution, should the first  
15 solution not work.

16 MS. POND: So it may just be the way  
17 we're wording what you want. I mean, I -- you  
18 know, the changes over time versus the  
19 spreadsheets from this many times -- all -- I  
20 think that we maybe should talk about how to  
21 word that request.

22 MEMBER BOWMAN: Okay.

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1 CHAIR MARKOWITZ: Ms. Splett.

2 MEMBER SPLETT: I've got a couple of  
3 examples of something I got out of Oak Ridge  
4 that I'd like to ask a couple of specific  
5 questions, if that's allowable, from the SEM.  
6 Mr. Domina, do you want to help over on this --

7 MEMBER DOMINA: Yeah.

8 MS. POND: If they're going to be  
9 new, just keep in mind we may or may not be  
10 able to answer them off the cuff here today,  
11 and we might have to take them back.

12 MEMBER SPLETT: I will say that they  
13 are SEM printouts for a couple of specifics  
14 that show no entries or limited entries, and  
15 the year, the two years before that, there were  
16 multiple entries. And we're just trying to  
17 understand -- we've been told that things  
18 aren't being taken out. I think we have  
19 multiple examples of where that has happened.

20 We're just trying to understand why  
21 that is, and how that's logged, and who's made  
22 the decision. It's not intended to be a

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1 "gotcha" moment. We just are really struggling  
2 with that.

3 CHAIR MARKOWITZ: Yeah. So we're --  
4 I guess the Board members, we're going to raise  
5 an issue here. And whether we get a definitive  
6 answer or not at this moment is uncertain.

7 MS. POND: Okay.

8 CHAIR MARKOWITZ: But we'll raise  
9 the issue, try to clarify the issue. And then  
10 if we can get a response now, fine. If it's a  
11 little bit later, that's fine too.

12 MEMBER SPLETT: Why don't you put  
13 105(c) up and why don't you talk to that one,  
14 okay? That's the K-25 labor category laborer.  
15 K-25. That would be in Oak Ridge.

16 MR. TURCIC: Okay.

17 MS. POND: Are you able to see the  
18 screen? Pete?

19 MR. TURCIC: Yeah. I -- what's the  
20 question?

21 MS. POND: Yeah. I just want to  
22 make sure you can see the screen as he's

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1 scrolling to it.

2 MR. TURCIC: Oh, no. I can't see  
3 the screen at all. I haven't seen any screen.

4 MEMBER SPLETT: Okay. Let's put the  
5 labor category labor anyway.

6 CHAIR MARKOWITZ: Well, we're --  
7 we're looking at the SEM. Which facility, K-  
8 25?

9 MEMBER SPLETT: K-25, labor  
10 category, laborer.

11 CHAIR MARKOWITZ: Yeah, okay. K-25,  
12 then you get labor category, laborer, then  
13 you'll be looking at what we're looking at.  
14 And I might add that the added benefit is that  
15 Kevin Bird is now getting proficient at using  
16 the SEM.

17 MEMBER SPLETT: It should show 21  
18 matching criteria for toxic chemicals. Is that  
19 right?

20 MR. TURCIC: I can't see any of  
21 that.

22 MS. POND: Right. I think that Pete

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1 isn't actually on the Webex. He's just on the  
2 phone.

3 MR. TURCIC: No, I'm on the Webex,  
4 but the -- the screen is just black. It's been  
5 black.

6 MEMBER SPLETT: Okay. The same  
7 search that somebody printed out 4/13 of '21  
8 shows 63 criteria. So the question is between  
9 '21 and '23, what happened to 42 mentioned  
10 criteria? I mean I -- we're putting you on the  
11 spot, because you don't have the specifics.

12 So that -- we've got multiple  
13 examples. And just -- we just are really  
14 trying to understand it. With the change  
15 longs, that we took this chemical off for this  
16 reason, this chemical off for this reason, what  
17 would that change log look like?

18 MR. TURCIC: Well, first of all, I'd  
19 have to see -- I would have to see the labor --  
20 so you're saying labor category, laborer --

21 MEMBER SPLETT: Correct.

22 MR. TURCIC: And when you say -- you

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1 said that at some point there was 21?

2 MEMBER SPLETT: There are currently  
3 21.

4 MR. TURCIC: Twenty-one what?

5 CHAIR MARKOWITZ: The hazardous  
6 chemicals.

7 MEMBER SPLETT: We're looking at the  
8 potentially encountered by labor category.

9 MR. TURCIC: Okay.

10 MEMBER SPLETT: And two years ago,  
11 that same number was 63.

12 MR. TURCIC: Oh, okay.

13 MEMBER SPLETT: Now, could you go to  
14 --

15 (Simultaneous speaking.)

16 MR. TURCIC: I -- go ahead, I'm  
17 sorry.

18 MEMBER SPLETT: Okay. Would you go  
19 to Y-12, Kevin?

20 MS. POND: Yeah, Pete, I think that  
21 we're just going to take their questions and  
22 then take them back and respond to them once we

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1 have a chance to look into it.

2 MR. TURCIC: I think that's the  
3 best, Rachel, because, you know --

4 MEMBER SPLETT: Because I don't  
5 expect you to have that stuff at your --

6 MS. POND: Sure.

7 MEMBER SPLETT: -- fingertips.

8 MS. POND: Right, right.

9 MEMBER SPLETT: We understand that.

10 MR. TURCIC: Right.

11 MEMBER SPLETT: But these just came  
12 in. I just got these very recently. So are  
13 you at Y-12? Y-12, all the way down to the  
14 bottom. It's right above Yucca Mountain, and  
15 sheet metal worker.

16 MR. VANCE: Dr. Markowitz, can I  
17 chime in real quick and provide a clarification  
18 that might help slightly, and then maybe Pete  
19 can talk to it.

20 CHAIR MARKOWITZ: Sure.

21 MR. VANCE: So don't forget, there's  
22 also a separate category for construction sites

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1 all, which is a generic profile.

2 MR. TURCIC: Right.

3 MR. VANCE: And I believe there are  
4 categories for both laborer and sheet metal  
5 workers that may have a substantially larger  
6 number of toxins associated with the labor  
7 category. So if you're looking at the Y-12 or  
8 the Oak Ridge, you may get a refined list. But  
9 if you go to that construction site's all list  
10 for subcontractors, you may get a substantially  
11 larger number of toxins.

12 Pete, do you want to talk about that  
13 construction sites all profile? That might  
14 actually help explain this.

15 MR. TURCIC: Yeah. If -- for anyone  
16 -- for workers who worked for a construction  
17 company, labor categories, you know, for all  
18 construction sites have the information that's  
19 supplied through that labor category in the  
20 construction process.

21 Now, for -- and that would be  
22 covered by, you know, a contractor, a

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1 construction contractor, if they worked for a  
2 construction contractor. And so you would go  
3 to the all sites construction profile.

4 If they worked for a primary prime  
5 contractor doing construction work, you have a  
6 lot of the similar labor categories. And for  
7 people who may have worked for both, the list -  
8 - you know, the claims examiners would combine  
9 those lists.

10 MEMBER SPLETT: But I'm looking at  
11 exactly the same top of the spreadsheet where  
12 there's no indication go to construction,  
13 categories, or anything else. So as this  
14 shows, no hazardous chemicals. And in January  
15 19th of '21, it showed 21 matching chemicals.

16 And there's no explanation. If  
17 somebody off the street is searching or an  
18 authorized representative is searching, this is  
19 not intuitively that perhaps there's another  
20 place that they need to search. There's no  
21 annotation on the form to do that. And again,  
22 probably not expecting an answer right now.

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1           Mr. Domina, did you have something  
2 you wanted -- did you want to --

3           MR. TURCIC: What were those years?  
4 What were those years again?

5           MEMBER SPLETT: Obviously, the  
6 current one and the previous one. There was in  
7 January 19th of '21 and May 13th of '20 that  
8 showed 21 matching criteria. And then in '23,  
9 there's --

10          MR. TURCIC: And '23, this year?

11          MEMBER SPLETT: Yes. Yeah, of this  
12 year. Yes. October 19th of '23.

13          MS. POND: Dr. Markowitz, it's  
14 Rachel. I'm assuming we can get these in  
15 writing following this sub-lecture --

16          MR. TURCIC: Yeah.

17          MS. POND: -- we get it, correct?

18          CHAIR MARKOWITZ: Yeah. We --

19                 (Simultaneous speaking.)

20          MR. TURCIC: Yeah.

21          CHAIR MARKOWITZ: -- will submit  
22 these examples with related questions in

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1 writing. We're not expecting any real answers  
2 at the moment. It's really just helpful to  
3 have a little bit back and forth so that we can  
4 clarify and make sure we're asking questions  
5 that make sense to you. That's our goal at the  
6 moment.

7 For instance, this distinction  
8 between crafts trades, which are treated in two  
9 separate places, one is construction workers,  
10 and otherwise, at the main facility site. So  
11 sheet metal workers are going to appear on both  
12 places because --

13 MR. TURCIC: Right.

14 CHAIR MARKOWITZ: -- they might be  
15 employed full time at the site. They're going  
16 to be then by the site if it's by construction  
17 contractor, or there'll be elsewhere. So that  
18 clarification helps us with our questions.

19 MR. JANSEN: And I'll just add, it  
20 would be helpful to get a copy of the SEM  
21 printouts so we could potentially put them on  
22 the website.

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1                   MEMBER SPLETT:       Dr. Markowitz,  
2                   that's the majority of my comments. We have  
3                   other examples that we can provide, but those  
4                   are really my overriding questions. I don't  
5                   know if the rest of the Board wants to go  
6                   through the larger documents. Up to the  
7                   remainder of the Board.

8                   CHAIR MARKOWITZ:       Well -- Dr.  
9                   Bowman.

10                  MEMBER BOWMAN:    Sorry. Just on the  
11                  additional examples, I think it could be  
12                  helpful to go through some of the additional  
13                  examples if you think the sort of initial  
14                  ideas, like we just talked about, that there  
15                  might be different types of related categories  
16                  if that could help us revise them. If they're  
17                  categorically identical, I would maybe not.  
18                  But if there's some of your examples that are  
19                  categorically different, we might get some  
20                  insight to help.

21                                    (Off-microphone comments.)

22                  MEMBER SPLETT:    Excuse me. We were

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1 just looking at some of the reactors from  
2 Hanford, and about some of the information is  
3 assuming to be inconsistent. And even the  
4 function of the reactors and the current titles  
5 seem to be inconsistent. But I think that we  
6 do need to provide that to DOL in writing. I,  
7 you know, want to catch people off base.

8 One of the things that I have to  
9 personally take some humor to it. Apparently  
10 we have rats and mice in one reactor, but five  
11 miles away, the other reactors, all through the  
12 Hanford site, that's apparently, they all just  
13 congregated at one reactor. That obviously was  
14 the only one that got identified.

15 (Off-microphone comments.)

16 MEMBER SPLETT: Yes.

17 (Simultaneous speaking.)

18 MR. TURCIC: Well, let me explain  
19 that. I'll tell you exactly how that happens.  
20 All we put in SEM is information that we can  
21 validate and verify. So --

22 MEMBER SPLETT: Well, to verify --

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1 MR. TURCIC: -- there must be --

2 (Simultaneous speaking.)

3 MEMBER SPLETT: -- there's mice at  
4 the other reactors.

5 MR. TURCIC: Well, but we need a  
6 document. If you can -- if you have a document  
7 that shows us some way, then we would, you  
8 know, that would be put in.

9 MEMBER SPLETT: Mr. Turcic, I'm  
10 sorry, that was -- it was a joke. I apologize.  
11 But we can also -- I can also tell you having  
12 been in multiple facilities, we also have  
13 snakes in there, so. But I don't have any  
14 documents, but I have seen them and didn't  
15 enjoy that, so.

16 CHAIR MARKOWITZ: Yeah. Mr. Domina.

17 MEMBER DOMINA: I just have a  
18 comment on what Mr. Turcic said about having to  
19 have a document. I'll just give you an example  
20 for something, like when they're going to some  
21 of the reactors that we're decommissioning and  
22 they're digging up burial stuff, many, many

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1 times over the years, they've stumbled across,  
2 quote, suspect fuel. And I'll clarify that  
3 because it's really fuel, it's just that it's  
4 not in the DOE inventory. And so then when it  
5 goes from whatever place and it -- most  
6 recently, it would get splashed at one of the K  
7 East or K West basins, then all of a sudden  
8 it's called fuel.

9 But when you have a worker digging  
10 it up, what they would do, they would have  
11 operations go over and identify it, and you  
12 would see a laborer or someone holding a white  
13 piece of paper with his bare hand behind this  
14 piece of fuel. And then all of a sudden, yeah,  
15 we got to handle it, get it stored. And then  
16 as soon as it goes in the basin and splashed  
17 into water, it's considered fuel. But in the  
18 meantime, the guy could put it in pocket, you  
19 know? And I think that the way some of this is  
20 done, you have to know more specifics on how  
21 things were done at each site.

22 And just like earlier, Mr. Turcic

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1 brought up when he was talking about the last  
2 big review was in 2015, and then he talked  
3 about CFR 851. Well, 851 didn't come in till  
4 1995. So it raises a lot of questions for me  
5 on what they did prior to 1995 because we know  
6 there's a lot of issues when 851 was actually  
7 implemented at different places on different  
8 sites.

9 Just like the problem with we have  
10 CFR 850 with beryllium, a lot of these sites  
11 still don't have a comprehensive beryllium  
12 program. We've been fighting in Hanford since  
13 2008 with it when DOE sent the thing out to  
14 have a program where it's the same across site.

15 MR. TURCIC: But that's exactly why  
16 -- that's exactly the point I was making. That  
17 is why what SEM is intended to be is the  
18 validation of information. And, for example,  
19 the SEM would not add in that a site had a  
20 beryllium program or anything else unless we  
21 had a document that showed that it was  
22 implemented.

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1           And as far as -- you're absolutely  
2 right, there's a lot of ways people were  
3 exposed to things that aren't in SEM, and  
4 that's why the processes, the claims process,  
5 is, you know, DOL has processes to handle that  
6 kind of information.

7           CHAIR MARKOWITZ:     This is Steven  
8 Markowitz.     Meaning the occupational health  
9 questionnaire in the interview, any affidavits  
10 or coworker affidavits would be where that  
11 information would be contained, right?

12          MS. POND:     Yes.     I believe so.

13          CHAIR MARKOWITZ:     Right.     Right.     I  
14 think we'll probably get back to that a little  
15 bit later.

16          MR. TURCIC:     And, Dr. Markowitz, I  
17 can point out that when we get -- when we get  
18 occupational health histories as part of the  
19 DAR request in a SEM mailbox, that information  
20 goes into the response in that mailbox, and  
21 that often ends up being an addition -- a  
22 revision to that profile.

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1 CHAIR MARKOWITZ: So, Mr. Turcic,  
2 this is Steven Markowitz. So you're meaning an  
3 individual claimant's occupational health  
4 questionnaire might end up in your mailbox as -  
5 -

6 MR. TURCIC: Yes. We get it every -  
7 -

8 (Simultaneous speaking)

9 CHAIR MARKOWITZ: -- as submitted by  
10 the claimant I mean?

11 MR. TURCIC: No, no. It's submitted  
12 by the district. When the district office --  
13 very often, it will be things like labor  
14 categories where labor categories, a claimant  
15 in the occupational history said that, you  
16 know, this is what labor category they had. A  
17 very recent one was a transportation certifying  
18 official, and the SEM did not have a  
19 transportation certifying official as a labor  
20 category.

21 Based on the information in the DAR,  
22 which included information that DOE in the

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1 claims verification and the occupational  
2 history, we were able to combine that, and now  
3 that is currently being added so that the  
4 transportation certification official is being  
5 added as an alias to a base management  
6 specialist at that site because of the  
7 information that was, you know, provided in  
8 those documents. And that happens quite often.  
9 We get probably eight to ten SEM mailbox  
10 questions a month.

11 CHAIR MARKOWITZ: And the source of  
12 that information is -- are the claims examiners  
13 or their claimants?

14 MR. TURCIC: Claims examiners and  
15 information that are in the claimant's file  
16 they send to us, you know, to support when  
17 they're asking their question. But the exact  
18 same process is available and has happened a  
19 lot. I'll give you a perfect example where  
20 information we received through the IAS through  
21 the Internet Accessible SEM where the public  
22 submitted information relative to

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1 trichloroethylene.

2 And what happened was the public  
3 submitted information that trichloroethylene  
4 was used as a degreaser by not only the  
5 electrical maintenance folks but also the  
6 instrument technicians and the electronics  
7 technicians. Based on that information, we  
8 looked at all the sites and identified that TCE  
9 was used at a lot of sites as a degreaser and  
10 primarily by the electrical maintenance people.

11 But based on the information that  
12 was submitted through the public, by the  
13 public, we put together a white paper and  
14 suggested that TCE be added also to the  
15 electronics technician and the instruction  
16 technicians. That went to DOL. DOL agreed  
17 based on the information we had. And so we  
18 went back through all the sites that did not  
19 have TCE in the electronics technician  
20 category, labor categories, and added that in.  
21 So that was about seven sites where that  
22 happened, and that was recently.

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1 CHAIR MARKOWITZ: And just a quick  
2 follow up. Steve Markowitz. Just a quick  
3 follow up to that. The public information that  
4 you received, were those DOE documents,  
5 contractor documents? Or were those the  
6 observations or perceptions of, say, former  
7 workers?

8 MR. TURCIC: It started out as the  
9 observation, and then, in our research, we  
10 found information. We got information from DOE  
11 that, you know, helped for us to justify in  
12 that white paper to make that change.

13 CHAIR MARKOWITZ: Okay. Thank you.  
14 Other Board members have questions, comments?  
15 Ms. Splett.

16 MEMBER SPLETT: I would really like  
17 to take Rachel up -- or excuse me, Ms. Pond up  
18 on her recommendation to have an in-person demo  
19 because there's nothing I would like better to  
20 feel like the SEM was totally responsive and I  
21 just didn't know how to operate it properly.  
22 Again, back to the construction workers versus

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1 --

2 CHAIR MARKOWITZ: Right.

3 MEMBER SPLETT: -- a specific  
4 facility. So I think there is a lot of us that  
5 would really like to do that. And I don't know  
6 whether that's something that could be done  
7 before our next six month meeting or not, but I  
8 do believe it needs to be done in person.

9 CHAIR MARKOWITZ: Well, we can do it  
10 before the next six month meeting. Yeah.

11 MEMBER SPLETT: But thank you for  
12 the offer.

13 MS. POND: Absolutely. I think  
14 it'll help with a lot of these questions to  
15 kind of understand that. There's a lot of  
16 nuances, and that's why we often have a lot of  
17 trainings. We try to have webinars for the  
18 public to understand how to search it and that  
19 sort of thing. But, yes, we'll set that up.

20 CHAIR MARKOWITZ: So are there other  
21 questions relating to the SEM while we have Mr.  
22 Turcic on the line?

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1 Well, let me just -- first of all,  
2 Mr. Turcic, thank you, both for your effort to  
3 get here, which, unfortunately, wasn't  
4 successful. But also for being on the line  
5 today, and to be willing to --

6 MR. TURCIC: You're welcome.

7 CHAIR MARKOWITZ: -- engage in  
8 clarifying discussions. So thank you for that.  
9 Were there any other additional comments you  
10 wanted to make, Mr. Turcic?

11 MR. TURCIC: No. Not right now.

12 CHAIR MARKOWITZ: Okay. So then we  
13 should move on, I think. We're running a  
14 little bit ahead on the schedule. That's good.  
15 I think we can go to the industrial hygiene  
16 recommendation that we made previously, and  
17 Department of Labor did not fully accept that  
18 recommendation, so we wanted to discuss our  
19 views on that and whether there was some  
20 modification or some improvement we can make.  
21 I think there's a PowerPoint here. Dr.  
22 Cloeren.

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1 (Off-microphone comments.)

2 CHAIR MARKOWITZ: So if -- just for  
3 clarification, this is the -- we're moving on  
4 to the topic that we had scheduled for 1:15,  
5 so.

6 MEMBER CLOEREN: I sent it to Kevin,  
7 but Kevin's out of the room.

8 CHAIR MARKOWITZ: Oh, great. So you  
9 should have -- Stefan, you have it.

10 MR. STEFAN: That's it, right? The  
11 one I'm showing.

12 CHAIR MARKOWITZ: No. No. It's the  
13 other one. It's the Cloeren one.

14 MR. STEFAN: Okay.

15 (Off-microphone comments.)

16 CHAIR MARKOWITZ: No, that's the  
17 medical one.

18 MR. STEFAN: Oh, okay. One second.  
19 The industrial hygiene report?

20 MEMBER CLOEREN: Right.

21 MR. STEFAN: Okay.

22 MEMBER CLOEREN: Okay. By way of

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1 background, in May, we did recommend modifying  
2 the expectations around the industrial hygiene  
3 report to include more details about what data  
4 was reviewed, what was available to review,  
5 what it showed. We also recommended referring  
6 to the case file where there were data to  
7 support the conclusions.

8 We recommended that there be the  
9 expectation of an explicit statement about any,  
10 like, lack of case-relevant data beyond what's  
11 available in the site exposure matrix and to  
12 share that information in kind of an organized  
13 way, a new table format.

14 Just to remind everybody, the  
15 current procedural guidance is that the  
16 industrial hygienist will review all the  
17 information, and using a combination of the  
18 information and their experience, characterize  
19 the exposure to whichever, you know, maybe a  
20 variety of chemicals, and a variety of jobs,  
21 and a variety of different time periods, but to  
22 characterize each of those as significant,

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1       between significant -- or between incidental  
2       and significant, or incidental, or no exposure,  
3       no evidence of any exposure. And then within  
4       significant, to then whether or not the  
5       exposure is high, moderate, or low. So those  
6       are kind of the categories that the industrial  
7       hygienist can use in the current procedural  
8       guidance to classify the exposure.

9               The rationale for our recommendation  
10       is that by synthesizing either a whole lot of  
11       data, which, I think is rare, but it's  
12       possible, along with the site exposure matrix,  
13       you know, findings, and then combining that  
14       with the industrial hygienist's knowledge into  
15       a conclusion, that misses the opportunity to  
16       share details with other experienced people,  
17       like the claims examiner and the contract  
18       medical consultant, that would provide more  
19       information about the type of exposure, the  
20       route of exposure, you know, inhalation,  
21       ingestion, skin absorption, intensity,  
22       frequency, duration.

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1 All of these are used, you know, in  
2 industrial hygiene thinking, basically. Also,  
3 calendar timing, use of PPE if that's  
4 available, which, you know, may not be in some  
5 cases.

6 But, anyhow, we thought that the  
7 synthesis of pulling together all the  
8 information and spitting out a conclusion about  
9 significant high, significant moderate, and  
10 significant low, incidental, between  
11 significant and incidental, or no exposure  
12 missed the opportunity to share important  
13 information about the details. How is that  
14 conclusion reached? Next slide.

15 This, just to remind everybody, was  
16 kind of what we proposed in a table format, you  
17 know, providing information about each of the  
18 exposures. And so it would provide details  
19 about each of these things. And then we also -  
20 - in the version that we actually submitted,  
21 this is an older version of it, we included the  
22 request that kind of page numbers from the file

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1 be included. Like, where did you find this  
2 information? Next slide.

3 And so the response was an agreement  
4 that the new table format, or something along  
5 these lines, would be helpful if the industrial  
6 hygienist found an exposure to be significant,  
7 but not in other cases. Not if they did not  
8 find it to be significant. And there was also  
9 agreement to add a data field that explains the  
10 type of exposure, whether it was direct,  
11 bystander, or in the area when it was used.

12 But, basically, there was  
13 disagreement with other recommendations,  
14 including specifying where in the various  
15 sources of data that were reviewed, the data  
16 supporting the conclusions were found. And we  
17 also received an example of an IH report, a  
18 redacted industrial hygiene report that was a  
19 lot more detailed than the usual industrial  
20 hygiene report.

21 And I've reviewed, you know, several  
22 of them over the years, and I thought it was a

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1 pretty good IH report that provided a lot more  
2 detail than we typically see. So I'm not sure  
3 it was a typical one, but even though it was  
4 more detailed than the typical one, I think  
5 there were still some problems that maybe  
6 demonstrate what we're trying to persuade the  
7 Department about. Next slide.

8 So this is an excerpt from the  
9 report, and one of the things that we wanted to  
10 point out is that the industrial hygienist had  
11 been asked about whether any of the pre-1990  
12 jobs could be -- and this was related to a  
13 hearing loss claim, and so the question was  
14 about solvent exposure and whether the claimant  
15 was in one of the covered job categories. And  
16 so the question was whether any of the jobs  
17 that the person had been in would be synonymous  
18 with some of the covered job categories. And  
19 the industrial hygienist consultant said that  
20 it was beyond the scope of the referral and  
21 can't be addressed.

22 We felt that, yeah, there is an

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1 opportunity to interview the worker. We don't  
2 see this done very often. Actually, I don't  
3 think I've ever seen any evidence of an  
4 interview. But an interview would be a really  
5 good way to try to clarify whether the, you  
6 know, the jobs that were listed are synonymous  
7 just by going through with the person, what it  
8 was they were doing. So just a comment. Next  
9 slide.

10 The industrial hygienist also used  
11 the language that we understood they were no  
12 longer supposed to be using about how, you  
13 know, the problems really existed before the  
14 mid-'90s, and after the mid-'90s things were  
15 safer. So we thought that was a problem, and  
16 we thought that that was not really supposed to  
17 be used in the reports anymore, especially when  
18 there's not data from a facility to support  
19 that, wow, you know, at this facility,  
20 everything got, you know, much better after the  
21 mid-'90s. Next slide.

22 The industrial hygiene report also

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1       said -- and this is, I think for myself, at  
2       least, speaking for myself -- this is a problem  
3       area because in almost every industrial hygiene  
4       report I've read, they refer to many different  
5       sources of information, and then summarize, I  
6       reviewed all this stuff, and my finding is  
7       this.     But they don't really say what they  
8       found, what each of the documents that they  
9       reviewed had, and I think that that is actually  
10      really relevant.

11                You     know,     I     reviewed     the  
12      occupational health questionnaire, well, okay,  
13      but what did it say?     I reviewed the EE3.  
14      Okay.     So that tells the job categories.     I  
15      reviewed the site exposure matrix and the  
16      physician's letter.     But the industrial  
17      hygienist in this report is not sharing  
18      anything from those sources with other people  
19      with expertise to maybe process some of that  
20      information.     Next slide.     And also the DAR  
21      wasn't listed for whatever reason.

22                And so I wanted to just throw out

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1 this example to you. That paragraph -- or  
2 actually, that industrial hygiene report would  
3 apply to either of these situations. A  
4 situation where there may be a DAR that shows  
5 monitoring for the work area where the claimant  
6 was working with no problem exposures. I mean  
7 that would be -- that would be very important  
8 information if that information were available.

9 That the OHQ exposure information  
10 was explored with an interview. That the site  
11 exposure matrix indicated plausible exposure  
12 opportunities. And that the conclusion  
13 includes the site exposure matrix, but it's  
14 corroborated with other data sources.

15 And this is what the CMC's maybe  
16 believing when they get their industrial  
17 hygiene reports because there's implication  
18 that I reviewed all these sources of data, and  
19 all these sources of data helped me draw my  
20 conclusion. But the reality, honestly, is  
21 that, most of the time, it's the site exposure  
22 matrix information. But that's not explicit,

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1 right, in the reports.

2 And speaking as an occupational  
3 medicine physician, I would always want to  
4 review an occupational health questionnaire  
5 myself. I wouldn't want someone else to review  
6 it and tell me, you know, what I need to know  
7 from it. And I think that's a disservice to  
8 the whole system to not share the OHQ. But in  
9 any event.

10 So the reality is there's usually no  
11 relevant DAR data. Who knows what the OHQ is  
12 saying. And this -- I'm sure the site exposure  
13 matrix is used, you know, very carefully and  
14 thoughtfully by the consultants. Next slide.  
15 But these are two different situations, right?  
16 And so if the end user of the report is making  
17 the assumptions on the left, they may draw much  
18 different conclusions than if they understood  
19 that all they're really going on is what's in  
20 the site exposure matrix. Next slide.

21 So this is important. And this is  
22 basically what I just said. And I think that,

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1 if we had a transparent process, that would  
2 make clear what was found in each of the  
3 different sources, including there was no  
4 specific site information. There was no  
5 monitoring records, you know, from the site.  
6 And I think that's the last slide. So that's  
7 just for discussion.

8 CHAIR MARKOWITZ: Okay. Thank you.  
9 That was very clear. Board members have  
10 comments, questions? So -- Steve Markowitz --  
11 so you're saying that in the IH report, that if  
12 there is specific information in these other  
13 sources aside from the SEM, that that  
14 information should not -- should be  
15 specifically noted in the report, and the  
16 source should be identified?

17 MEMBER CLOEREN: Correct.

18 CHAIR MARKOWITZ: And likewise, if  
19 those other sources don't have any useful  
20 information, that should also be specified?

21 MEMBER CLOEREN: Correct.

22 CHAIR MARKOWITZ: All right.

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1           MEMBER CLOEREN: And I think that --  
2 and that's more often the case, right?

3           CHAIR MARKOWITZ: Right, right.  
4 That seems like a pretty straight forward thing  
5 to do, actually. Could you go back to Excerpt  
6 2 for slide? So I think you pointed this out  
7 that this is an excerpt that contains reference  
8 to the mid-1990s, that after the mid-1990s,  
9 programs were well developed fully implemented,  
10 and, later, it says that the likelihood of  
11 significant exposures was greatly reduced after  
12 the mid-1990s. And this statement is included  
13 as a general statement. It's not in this  
14 particular case substantiated by any monitoring  
15 data or any other data.

16           And this is a not-so distant cousin  
17 from previous language that centered on 1995,  
18 which the Department actually rescinded in  
19 2017. The Board pointed this out that this was  
20 an arbitrary kind of cutoff date, and it was  
21 prejudicial. And the Department agreed and  
22 rescinded that. And this is a somewhat softer

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1 version of the same language.

2 And I guess, in the absence of data  
3 to support that statement, the question is,  
4 what real value, real truth value, can you  
5 attribute to this general statement? And the  
6 problem is, of course, that there's rarely any  
7 real data from the worksite if you're just  
8 talking about industrial hygiene monitoring  
9 data one way or the other, that there was  
10 exposure, there wasn't exposure.

11 I don't think there should be a  
12 prejudice that in the absence of industrial  
13 hygiene data, there was over exposure. I don't  
14 think that should be the assumption because why  
15 would you make that assumption. And likewise,  
16 on the flip side, I don't think in absence of  
17 industrial hygiene data, you could assume that  
18 everything was fine.

19 But the reality is that those data  
20 don't exist for -- and they probably still  
21 don't exist, you know, at the various  
22 worksites. So then what do we do with this

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1 observation, which we've seen repeatedly in  
2 industrial hygiene reports that the things got  
3 better throughout the '90s.

4 And the implication is that, to  
5 quote this excerpt, the second to the -- second  
6 line from the bottom, circumstances leading to  
7 a significant exposure would likely have been  
8 identified or documented in employment records,  
9 end of quote.

10 Is that true that it would have been  
11 identified in employment records? I'm  
12 skeptical about that. So I don't think the  
13 prejudice should go in either direction around  
14 a given timeframe.

15 And by the way, for people who  
16 worked at these facilities who are on the  
17 Board, I mean over the decades, conditions did  
18 get -- health and safety conditions did,  
19 generally speaking, get better. Is that right?  
20 That doesn't mean that every particular  
21 situation, every given task or job title, et  
22 cetera, you know, experienced no important

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1 exposures. But, in general, conditions did get  
2 better. The question is can you really  
3 translate that into a determination for an  
4 individual claimant in an IH analysis?  
5 Personally, I'm skeptical. But I'd like other  
6 people's opinions. Dr. Van Dyke.

7 MEMBER VAN DYKE: This is Mike Van  
8 Dyke. I agree with what you're saying. I  
9 don't think that these things were very well  
10 documented, and they were definitely not well  
11 documented in employment records themselves. I  
12 think it's hard to get away from the bias as an  
13 IH that things did get better. And I think  
14 that, in their minds, in the minds of  
15 evaluators, they're going to use that in their  
16 minds.

17 However, I think that, you know, the  
18 lack of documentation cannot be interpreted as  
19 lack of exposure. And even if they said  
20 something like this and they ended it with the  
21 lack of documentation cannot be interpreted as  
22 lack of exposure, it would be much better. But

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1 this does leave the CMC down the road of, oh,  
2 things were great, good record keeping, must be  
3 no exposure. And that's a very biased trial to  
4 lead someone down.

5 CHAIR MARKOWITZ: Mr. Key.

6 MEMBER KEY: Yeah. I think we've  
7 lost our focus here. Some may have never had  
8 it because we go back to the original  
9 legislation and the intent of Congress, again,  
10 where there was no documentation at the site  
11 IH, health visits. Otherwise, there's specific  
12 language put in the statute that should direct  
13 all of us in our activities as an illness that  
14 was as least as likely as not that occupational  
15 exposure or a toxin created the causation,  
16 correlation, or illness.

17 And that specific language was put  
18 in there for a reason, so where there is  
19 absence of data. This is very vague, this IH  
20 report statement here. That provides no basis  
21 for approval or denial. I think you need to go  
22 back to the intent of the act and that specific

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1 language.

2 CHAIR MARKOWITZ: The other thing --  
3 Steve Markowitz -- is that it's one thing to  
4 think that conditions may have likely improved  
5 over time, but actually, that's not really the  
6 point of interest when examining an individual  
7 claim. Here's a person who has an illness, a  
8 particular person with a particular -- his job  
9 history who has an illness. And so the  
10 question is did this person have exposures that  
11 may have been significant or not? And for  
12 that, you need to know as much as you can about  
13 that particular person and their own history.

14 And so what was generally occurring  
15 in the facility is one thing, but it may be  
16 quite different what this individual person  
17 experienced. And, frankly, you know, the  
18 source of that really is going to be the  
19 occupational health questionnaire, the  
20 interview, the like, you know, what that  
21 particular person reports.

22 But let me ask Mr. Key something,

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1 and I don't mean to ask you, but since there  
2 was very little objective industrial hygiene  
3 data showing one way or the other, over  
4 exposure or, you know, insignificant exposure.  
5 So to me, in the absence of information to lean  
6 in the favor of the claimant, does that mean --  
7 which I appreciate, that was part of the  
8 original act. In fact, the whole establishment  
9 of the three gaseous diffusion plants as we  
10 didn't know what the radiation levels were, so  
11 therefore, we're going to compensate them for  
12 one of, whatever, 22 cancers or whatever. That  
13 was part of the act.

14 But what does that mean, in general,  
15 for toxic substances? Does that mean everybody  
16 gets compensated because we're going to lean in  
17 their direction? And this is not directed  
18 towards you, per say. I'm just saying in  
19 general, then how do you approach this if you  
20 say that, well, okay, we're going to be  
21 favorable to the claimant and we don't have any  
22 real data, and so, okay.

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1           MEMBER KEY: I don't think you have  
2 to approach it that way. There is numerous  
3 incidents where workers were exposed, including  
4 myself, to asbestos. At the end of the day  
5 going to the shower room, completely covered  
6 white with asbestos dust, no industrial hygiene  
7 monitoring on the jobsite.

8           Our industrial hygiene department  
9 consisted of one person until the late 1980s,  
10 and then it had grew to three. There was no  
11 field monitoring, job-specific scope and  
12 monitoring going on. That did not even come  
13 into play, especially, and I can speak for the  
14 Paducah gaseous diffusion plant, until the mid-  
15 2000s where there was a robust build up an  
16 industrial hygienist and health visits  
17 technicians.

18           And also, just because a chemical  
19 had been outlawed and a contractor was aware of  
20 that, that did not mean that the contractor had  
21 the workers go out and secure all of those  
22 banned chemicals and bring them in and out of

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1 the available inventory to use. Quite the  
2 opposite. They left them out there and used  
3 all of them in the meantime trying to find a  
4 replacement to bring on site.

5 So I think it has to be in favor of  
6 the claimant, especially up until, as I stated,  
7 the late 2000s where you had a more robust, on-  
8 job site health visits and industrial hygiene  
9 technicians.

10 CHAIR MARKOWITZ: So can we get  
11 other comments, questions? Oh, yeah, I'm  
12 sorry. Mr. Domina.

13 MEMBER DOMINA: I think you have to,  
14 you know, when you work at these sites and put  
15 stuff into perspective, a prime example is we  
16 would have more one of the national labs,  
17 Pacific Northwest National Lab, come out, like,  
18 in a building where we worked to try and  
19 replicate the way the air moves, ventilation  
20 because of issues with contamination, with  
21 uptakes of everything. It's never the same  
22 twice.

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1           And it's no different than during  
2 these times when we're working. The reason  
3 they don't monitor -- because they don't want  
4 to know the answer. And, you know, I mean when  
5 you can -- when it's snowing asbestos on a  
6 reactor startup, and I know you may think I'm  
7 blowing smoke, but when you see it yourself,  
8 you think they're going to put a monitor in  
9 there? And then you're doing that every 28  
10 days. It never goes away. You know, and then  
11 you're out there sweeping it on, you know, to  
12 clean it up. And like I said, we ventilated.  
13 In these old building, it ventilated to  
14 atmosphere.

15           But there's no filtered monitoring.  
16 We've had issues where people are standing  
17 shoulder-to-shoulder having lapel monitors and  
18 then an area monitor, and people end up with  
19 ingestion, inhalation, and the person next to  
20 them got nothing.

21           You know, this is, you know, we  
22 signed up for this, we got that, you know, but

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1 the type of work that we do, there's certain  
2 things they didn't want a monitor like stuff at  
3 the tank farms, the industrial hygiene didn't  
4 get real decent until about 2016, '17 when the  
5 Labor, you know, HAMTC did a stop work for any  
6 work on the farms unless you're wearing  
7 supplied air, SCBA. But then that causes a  
8 host of other issues. People slipping and  
9 falling in the winter, hurting their back when  
10 they land on one. Or some people, you know,  
11 the SCBA weighing half their body weight.

12 And then when they started  
13 monitoring some of these things, I mean if you  
14 go out there now, there's stacks. They spent  
15 millions of dollars to ventilate some of this,  
16 they knew it was bad. But you can't measure  
17 that in these people except when their health  
18 is declining and then you're going to say that  
19 they didn't have any exposure.

20 I mean I understand both sides of  
21 this table. There's a scale for monitoring,  
22 not monitoring, and, yeah, you don't give it

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1 all to the people and you also don't give it  
2 all to the other side. But it doesn't seem  
3 like the scale's very even.

4 CHAIR MARKOWITZ: Mr. Key.

5 MEMBER KEY: Yes. Kirk jogged my  
6 memory a little bit. I'll give you an incident  
7 that just happened within the last two years  
8 which I related to earlier today of the  
9 exposure to fluorine to approximately 16  
10 workers working a special project.

11 They had area monitors. They had  
12 lapel monitors. But they were instructed when  
13 the area monitor or lapel monitor went off, to  
14 turn on the industrial fans, to remove that as  
15 the engineering control away from them and to  
16 silence the monitors.

17 This group that we're going to file  
18 for, we have the documentation. It had to be  
19 reported to DOE either through their ORPS  
20 system, or their CARE system because one of the  
21 individuals suffered three days of blindness,  
22 had to be transported from the facility in a

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1 hospital -- or in an ambulance and stayed in a  
2 hospital for three days until his sight came  
3 back, and then repeated just migraines for like  
4 four months.

5 So, you know, has it improved?  
6 Certainly it's improved to a degree since the  
7 '50s and '60s. But we still have instances  
8 where, as Kirk said, monitoring is sometimes  
9 not done because the contractor doesn't want to  
10 know. If it hits a threshold, then that's a  
11 reporting requirement.

12 CHAIR MARKOWITZ: Mr. Catlin and  
13 then Dr. Cloeren, she's -- oh, go ahead.  
14 Marianne.

15 MEMBER CLOEREN: Yep. Dr. Cloeren  
16 here. I want to go back to the OHQ. I don't  
17 understand why that is not shared with the CMC.  
18 And I wonder -- I don't wonder, can I propose  
19 that the OH questionnaire be included with the  
20 packet to the CMC? And also I don't know  
21 whether -- can the CMC request the industrial  
22 hygiene consultant to do an interview if

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1 there's a conflict, for example, between the  
2 industrial hygiene conclusion on review of the  
3 SEM and what is being stated in the OHQ? Is  
4 there a mechanism for trying to resolve, you  
5 know, that difference and get some more  
6 information? Because like what you said about  
7 the SCBAs is really interesting, you're not  
8 going to get that from any place but the  
9 employee.

10 CHAIR MARKOWITZ: Steve Markowitz --  
11 oh, go ahead.

12 MEMBER CATLIN: Go ahead.

13 CHAIR MARKOWITZ: No, just to follow  
14 up to what she said. Yeah, I think  
15 recommending that the OHQ be given by the CE to  
16 the CMC as part of their evaluation in addition  
17 to the industrial hygiene report, that's a  
18 perfectly valid recommendation for the Board to  
19 make.

20 MEMBER CATLIN: Thanks, Mark Catlin.  
21 Yeah. I actually view the occupational health  
22 questionnaire that the Department -- the

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1 improved one the Department accepted a couple  
2 years ago from this Board really ought to be  
3 part of the IH report. I mean I think it  
4 should also go to the CMC. But in the IH  
5 report, they really ought to say -- they really  
6 ought to address what they saw in that report.  
7 And if they can refute it because they have  
8 data or if it doesn't make sense.

9 But I think a lot of times in the  
10 claims that I've looked at in my prior  
11 experience, the worker information in that good  
12 questionnaire will support the claim, and then  
13 there wouldn't be anything to refute it from  
14 the Department side. And then you would decide  
15 that there was some exposure. And I think  
16 that's a perfectly easy way to do it.

17 But in the IH reports I've reviewed,  
18 as you've described, they're usually very --  
19 like we've reviewed everything, but it seems  
20 like there's no problem here. And they don't  
21 really say they reviewed the questionnaire, and  
22 I know I've looked at some of the claims where

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1 you look at the IH report, and then you go  
2 through the questionnaire. And there's all  
3 sorts of potential exposures that are never  
4 addressed, and they just sort of get blanket  
5 kind of rejected.

6 So I think as the recommendation was  
7 to kind of make this more clear and make it  
8 more clean, I think the questionnaire ought to  
9 be -- ought to be something IHs have to address  
10 and not just sort of miss it. And I still  
11 think it should go to the docs, and the claims  
12 examiners should review it, too. But the IH  
13 has a way to look at those responses and weigh  
14 in on them, and maybe doing the interview also  
15 is, if there's any sort of questions. So  
16 thanks.

17 CHAIR MARKOWITZ: Dr. Bowman.

18 MEMBER BOWMAN: Yes. Thank you. I  
19 was just going to -- Mark, I think you make a  
20 very good point there with the IHQ being  
21 shared. I think the question that would easily  
22 come up in the mind of the CMC is what does the

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1 IH think about this element of the IHQ? And so  
2 making sure that those elements are addressed  
3 in the IH report would help with the clarity.  
4 We don't want to cause even more confusion and  
5 more -- potentially even delays in the  
6 processing of a claim if there has to be a  
7 bunch of back and forth.

8 So I think maybe with a  
9 recommendation to share the IHQ, we should say  
10 that it should be -- that the contents of that  
11 should be specifically addressed by the IH.

12 CHAIR MARKOWITZ: Steve Markowitz.  
13 I mean I understand the perception that, you  
14 know, you give the exposure information to the  
15 exposure expert, that's the IH. They look at  
16 everything. They interpret it. They prepare  
17 a, more or less, concise report. And then that  
18 expert report is handed over to the medical  
19 expert who now has the exposure expert input,  
20 and then takes it, combines it with the  
21 medical. And then makes a decision about  
22 causation or whatever.

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1           But actually, in reality -- that's,  
2 obviously, a useful thing. But in reality, the  
3 doc wants to see the primary information. And  
4 the OHQ is limited in amount, so it's not an  
5 overwhelming, certainly not a burden to the  
6 doctor.

7           And so, yeah, I mean they should see  
8 the OHQ in addition to the IH report because  
9 it's not one expert to the next. You know, the  
10 OM doc is an expert also in exposure. Not as  
11 much as the IH in measurement, but  
12 interpretation, probably. So that's why we  
13 need to see the OHQ. Okay. Having said all  
14 that, Dr. Van Dyke.

15           MEMBER VAN DYKE: No, there's always  
16 the physicians thinking they're industrial  
17 hygienists, right? No. I want to push back on  
18 that a little bit. I mean I think that that's  
19 true for many occupational medicine physicians,  
20 but I would like to know if you think that  
21 that's broadly true for the people that are  
22 doing these evaluations.

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1           CHAIR MARKOWITZ: Yeah. That's hard  
2 to know. I mean I think if you give those CMCs  
3 both the industrial hygiene report and the OHQ,  
4 that, you know, they'll decide what they're  
5 going to look at, pay attention to, and I'm  
6 sure there's variation in that. I don't see  
7 any downside in giving them the OHQ. If they  
8 ignore it, they ignore it, right? But at least  
9 having the primary data in addition to the  
10 industrial hygiene report I think would be  
11 useful.

12           Let me just say something else about  
13 the, you know, we have an example report that  
14 was sent to us in response to this  
15 recommendation that was nine pages long, a  
16 little bit longer than most of the IH reports  
17 we've looked at. Speaking as a physician, I  
18 don't generally read line by line every nine  
19 pages of an evaluation. I'm going to focus in  
20 on the summary table. And I realize that, you  
21 know, the advantage of a text narrative is that  
22 you can put in, I think, nuance.

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1           But it'll be very interesting to  
2 test what the CMCs actually use because -- and  
3 I know that was part of the DOL response is to  
4 look at what the CMCs, how they react to  
5 whatever. But I think that summary table is  
6 really key, and what's included and not  
7 included in that summary table because even if  
8 you read the whole nine page report, when  
9 you're sitting there making a decision, you're  
10 going to back to that summary table in terms of  
11 what your understanding is, unless someone  
12 disagrees with me about that. Dr. Van Dyke.  
13 Good. Disagreement.

14           MEMBER VAN DYKE: No. I'm circling  
15 back. I mean I think that, you know, what Dr.  
16 Bowman said around the IH should be required to  
17 respond to the reported exposures in the  
18 questionnaire I think is absolutely critical.  
19 And I think it's critical from the perspective  
20 of the claimant because the claimant, if they  
21 are not -- if those are not responded to, they  
22 feel like they're being ignored. And I also

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1 think it's important because there is a piece  
2 that, you know, there's a misinterpretation or  
3 a misunderstanding about what people are  
4 exposed to sometimes.

5 So providing that list of they  
6 reported that they were exposed to X, Y, and Z,  
7 and saying whether that is substantiated or not  
8 in the SEM would be really helpful. And there  
9 might even be an opinion on whether this is  
10 possible given what we know about their work  
11 history. So I think that that disconnect where  
12 they're just feeling like they're not responded  
13 to at all is the big problem here.

14 CHAIR MARKOWITZ: Yeah. Steve  
15 Markowitz. I think that's a good point. I  
16 also think that, and I don't know, Dr. Cloeren  
17 where exactly you were heading here, but I  
18 think we could fine tune, modify the  
19 recommendation to hit on some of these specific  
20 points that would add some specificity to the  
21 prior recommendation and might help the  
22 Department.

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1           So we don't have to do that right  
2 now in the four minutes before lunch, but we do  
3 have time -- would have time this afternoon and  
4 tomorrow morning to look at language and then  
5 discuss it and perhaps vote on it. Mr. Key.

6           MEMBER KEY: Yeah. Before we break  
7 for lunch, I guess this is a question to Rachel  
8 because I don't know the answer. Does the  
9 Department have access to the Department of  
10 Energy's ORPS reporting base and the other one  
11 where reports were filed at these locations on  
12 exposure, and if a claimant files a claim that  
13 occurred with an incident, let's arbitrarily  
14 say in the 1980s, do you have or do your CEs or  
15 someone within DOL have access that they can go  
16 into the DOE reporting systems and back to that  
17 timeframe to see the documentation that may  
18 possibly be there?

19           MS. POND: No. We don't have direct  
20 access to reports that DOE has. What we can do  
21 is ask for a DAR, which is a document  
22 acquisition request, which provides us with

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1 more detail about their exposures and any  
2 records that Department of Energy has, they can  
3 come back and provide us with that information.

4 And so when we do have, you know,  
5 reports like that, we will do whatever  
6 investigation we can, go back to DOE with a DAR  
7 request for more information. But that's the  
8 extent of it, and I don't know if Gail wants to  
9 elaborate on that, but our access is limited to  
10 what we can get from DOE. We don't have direct  
11 access to their records.

12 MEMBER KEY: Okay. I guess a  
13 follow-up. Can the claimant then -- is there a  
14 DOE representative that the claimant can  
15 contact that knows a specific incident, that  
16 they can get that information, thereby, submit  
17 it also with their claim?

18 MS. POND: I don't have the answer  
19 to that, but maybe Gail can help.

20 MEMBER KEY: I mean there's -- it  
21 intrigued me yesterday on our tour that the  
22 site medical director listed the guards and the

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1 fire department personnel as the top two labor  
2 categories on site for the EEOICPA program and  
3 going through their physicals. When we have  
4 these other sites across that firefighters and  
5 guards, you pull up their labor category,  
6 there's no exposures when we know that on site,  
7 not only did they fight fires that occurred on  
8 site, they went off site mutual aid agreement  
9 with the facility. And also they had the  
10 annual firefighting training that they  
11 intentionally set a specially built facility on  
12 fire to respond to that. So I mean there's  
13 exposures there, we know that. But yet,  
14 they're not included in the SEMs, being exposed  
15 to any chemicals whatsoever.

16 CHAIR MARKOWITZ: So -- oh, yeah.  
17 Ms. Splett. Go ahead.

18 MEMBER SPLETT: This is Gail Splett.  
19 I am not sure at Hanford when they do the DAR,  
20 if those CARES and ORPS reports are identified  
21 by individual names so that the staff could  
22 link to those, or how deep they would have to

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1 dig. I will find that out. Do you know if the  
2 reports, or Mr. Domina, if they have specific  
3 names in them or they talk about like employee  
4 one, employee two? I don't know the answer to  
5 that. But it's --

6 MEMBER DOMINA: Well --

7 MEMBER SPLETT: -- a great question.

8 MEMBER DOMINA: -- the other part  
9 that would play into that is a PAAA violation  
10 because I've had them try to -- let's see, make  
11 sure to use the right wording here -- suspend  
12 some of my guys that I represented because of a  
13 AAA violation, and then you come to find out  
14 it's the contractor's fault once you get a copy  
15 of the report. And to me this can also prove  
16 that a certain event or something did actually  
17 take place.

18 MEMBER SPLETT: What kind of  
19 violation? Did you say triple --

20 MEMBER DOMINA: Price-Anderson  
21 Amendment Act. When the DOE fines a contractor  
22 for --

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1 MEMBER SPLETT: Got you.

2 MEMBER DOMINA: -- a screw up.

3 MEMBER KEY: Yeah. I don't know the  
4 answer to your question, you know, if it lists  
5 the individual's name. But if we can get to a  
6 date and a location, and to me that's  
7 documented evidence that this person was, in  
8 fact, involved in that and submit that with  
9 their claim, absent of any monitoring data.

10 MEMBER SPLETT: I know that the Part  
11 B Board and NIOSH have requested from Hanford  
12 all the ORPS data, and we provided it all to  
13 them. But I don't know whether it was  
14 retrievable by individual's name or linked to a  
15 DAR when it was requested. But I will ask --  
16 find that question because I think it is  
17 something if it was retrievable, that that  
18 could be something that could be added to the  
19 DARs for the various sites.

20 CHAIR MARKOWITZ: Any other last  
21 comment, question before lunch? Yeah. Dr.  
22 Bowman.

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1           MEMBER BOWMAN: Yeah. I just wanted  
2 to link something that Jim and Marianne both  
3 said. At one point in time, Jim, you  
4 referenced the statutory setting of the  
5 criteria as being at least as likely as not.  
6 In my mind, that is highly similar to what  
7 Marianne was saying that in the absence of  
8 data, and also what Steven was saying, in the  
9 absence of data, we should not prejudice to  
10 either one way or the other.

11           I think there's a lot of  
12 similarities in at least as likely as not and  
13 to say there is an absence of data, so  
14 therefore, we cannot conclude an exposure or  
15 not an exposure. To me, those are very  
16 comparable. And so I think it's good to point  
17 that out that that links with that.

18           MEMBER CATLIN: But when you say  
19 absence of data, would you include the  
20 occupational health questionnaire as a piece of  
21 data, as data in the claim?

22           MEMBER BOWMAN: Yeah. I suppose it

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1 would, and this is why it's very important for  
2 that data to be commented upon. Yeah.

3 CHAIR MARKOWITZ: Okay. So we're  
4 going to break for lunch. We'll resume at  
5 1:15. Thank you.

6 (Whereupon, the above-entitled  
7 matter went off the record at 12:17 p.m. and  
8 resumed at 1:17 p.m.)

9 CHAIR MARKOWITZ: We can get started  
10 again. Dr. Friedman-Jimenez, you can hear us?

11 MEMBER FRIEDMAN-JIMENEZ: Yes, I  
12 can.

13 CHAIR MARKOWITZ: Okay. Good.  
14 Okay. So we're going to actually for a few  
15 minutes go back to the same topic, try to  
16 identify some elements of the discussion that  
17 might be used to form a new recommendation for  
18 the Board. We're not actually going to write  
19 that recommendation in committee right this  
20 moment. We just need to identify what pieces  
21 we want to put in it, and then later a written  
22 version will magically appear that we can

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1 modify and vote on. So, Dr. Cloeren, you want  
2 to start off this?

3 MEMBER CLOEREN: Sure. Okay. So  
4 there were several things in the letter back  
5 from the director. One of them had to do with  
6 agreeing with our proposal to use a summary  
7 table only if the industrial hygienist found --  
8 only for the exposures that were found to be  
9 significant. And I think that we could agree  
10 that that makes sense. It doesn't make sense  
11 to have a table about duration, et cetera, et  
12 cetera, for things that were incidental or not  
13 found to be exposures. So I think that's the  
14 first point of discussion.

15 CHAIR MARKOWITZ: Sure.

16 MEMBER CLOEREN: Everybody -- okay.  
17 The second --

18 MEMBER FRIEDMAN-JIMENEZ: Do you  
19 want it now or wait to the --

20 MEMBER CLOEREN: I don't know. How  
21 do you want to do this?

22 CHAIR MARKOWITZ: No, no. What do

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1 we have, what, maybe three or four points,  
2 right?

3 MEMBER CLOEREN: Three or four  
4 points. You want to go through them all?  
5 Okay.

6 CHAIR MARKOWITZ: Well, why don't  
7 you just briefly go down the three or four  
8 points.

9 MEMBER CLOEREN: Okay.

10 CHAIR MARKOWITZ: And then we'll --

11 MEMBER CLOEREN: Okay.

12 CHAIR MARKOWITZ: -- handle them one  
13 by one.

14 MEMBER CLOEREN: As we discussed  
15 earlier, we would like to recommend that the  
16 industrial hygienist should address all of the  
17 exposures that were claimed in the occupational  
18 health questionnaire, or otherwise by the  
19 claimant, whether that's in the doctor letter  
20 or claimant letter, or whatever. But that the  
21 industrial hygienist should specifically  
22 address what was purported, you know, by the

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1 claimant, the former worker.

2 That the industrial hygienist should  
3 specify what data was found in each of the  
4 sources that were listed as reviewed. Right  
5 now, we sort of lump it all together, I  
6 reviewed all these things and my conclusion is  
7 this. And so I think we feel pretty strongly  
8 that there's an obligation out of transparency  
9 to state, you know, what was found in the DAR,  
10 if the DAR was there, you know, what was found  
11 in the OHQ, what was found in, you know,  
12 whatever other documents may have been listed.

13 And if there was no other  
14 information, no information found in specific  
15 documents, then that should be explicitly  
16 stated that there was no exposure information  
17 available because I think right now, lumping  
18 them all together and saying I reviewed all of  
19 these things, and my conclusions are blah,  
20 blah, blah, can imply that there was some  
21 information where there was none. Right? Did  
22 I capture your thoughts pretty well? Okay.

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1                   And then finally, the OHQ should be  
2 shared with the CMC, or whatever doctor the --  
3 whatever doctor the claims examiner may be  
4 sending the industrial hygiene report to that  
5 the OHQ should be part of that transmittal  
6 because sometimes they'll send the industrial  
7 hygiene report back to the treating doctor, or,  
8 you know, the former worker program doctor, and  
9 the OHQ should be part of that. I think that's  
10 it.

11                   CHAIR MARKOWITZ: Okay. So you want  
12 to just start with the first one, which was?

13                   MEMBER CLOEREN: The table is only  
14 needed if exposures are found to have been  
15 significant. But even if they don't find --  
16 well, so the second point was whether it was  
17 found to be significant or not, the IH report  
18 should be addressing what was claimed.

19                   CHAIR MARKOWITZ: Okay.

20                   MEMBER CLOEREN: But the table only  
21 needs to include the data for exposures that  
22 were in any of the three significant groups.

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1 CHAIR MARKOWITZ: Low, medium, or  
2 high significant, right?

3 MEMBER CLOEREN: Yes.

4 CHAIR MARKOWITZ: Okay. Comments,  
5 discussion? Dr. Friedman-Jimenez?

6 MEMBER FRIEDMAN-JIMENEZ: Friedman-  
7 Jimenez, I'd like to respond to that. I think  
8 that part of the issue here that I think is  
9 important is transparency so that the claimant  
10 and their representatives all understand the  
11 rationale for a case being accepted or denied.  
12 And in particular, denied.

13 And so if the exposures that are  
14 classified as incidental are not included in  
15 the table, then that doesn't allow the claimant  
16 to understand the rationale for saying that the  
17 exposure was non-causal. And I would argue  
18 that there are some cases in which incidental  
19 exposures can cause disease.

20 For example, someone that has  
21 isocyanate exposure and occupational asthma,  
22 and become sensitized to isocyanates may be in

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1 a facility where the air levels are extremely  
2 low, even not measurable, and still get asthma  
3 attacks from that isocyanate and wind up having  
4 to leave their job. And so it has a  
5 significant -- quote, "significant" impact on  
6 their life. But it could easily be classified  
7 as an incidental exposure by an industrial  
8 hygienist because it doesn't have a classic  
9 dose response curve.

10 So I think that it leaves the door  
11 open for some real misunderstandings if we  
12 agree that the negative exposures or the  
13 incidental exposures don't need to be justified  
14 in any detail. I agree that you can't say, you  
15 know, how long is the duration as easily, but  
16 sometimes something is called incidental  
17 because it's a very, very low level, but over a  
18 long duration. And depending on the  
19 pathophysiology, that could be medically  
20 significant, although, industrial hygiene-wise,  
21 may seem insignificant. So I think the problem  
22 is with the word incidental.

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1 CHAIR MARKOWITZ: Actually -- this  
2 is Steve Markowitz -- I just want to follow up  
3 specifically on that, and there's also the  
4 category of more than incidental but less than  
5 significant, right? So it's not just the  
6 incidental ones that we're talking about.

7 I think the CMC should have access  
8 to that because it's a judgment as to whether  
9 an exposure was -- at what level it occurred.  
10 And the IH expresses their judgment. But for  
11 the CMC, we only have the universe of  
12 possibilities, and maybe I'm just repeating the  
13 comment that Dr. Friedman is making that they  
14 need to have that included in that universe.  
15 They may come -- they're likely to come to the  
16 same conclusion about its significance, but  
17 perhaps not. Dr. Bowman.

18 MEMBER BOWMAN: I was just going to  
19 comment further on this topic. I think that  
20 the table, of course, that the Board  
21 recommended use, you know, broke down various  
22 critical elements and are part of an overall

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1 exposure assessment duration amount, and so  
2 forth. And I think part of the reason that I  
3 interpreted the Department did not accept the  
4 recommendation was one of practicality in terms  
5 of being able to answer that.

6 So you can imagine a situation in  
7 which -- and George, I 100 percent agree with  
8 you an incidental exposure can, in fact, be  
9 causative of illness. I completely agree with  
10 that statement. But it may not be possible or  
11 as possible to fill out all those details if  
12 the information is missing. And so to require  
13 -- to ask for a requirement of details in which  
14 it's because of an absence of information, the  
15 IH is trying to make their best guess, that  
16 might be difficult to do with all the level of  
17 detail we asked in the table because I wouldn't  
18 say that -- I mean could we not consider, you  
19 know, we don't want to say an IH should not use  
20 the table unless it's significant. Just it  
21 becomes harder when it's incidental depending  
22 on the nature of the incidental.

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1 CHAIR MARKOWITZ: Dr. Vlahovich.

2 MEMBER VLAHOVICH: Kevin Vlahovich.

3 I would just be concerned that if there was an  
4 exposure that was claimed to have happened, and  
5 then was not even mentioned at all in the  
6 summary table, that that would be an omission  
7 that would be fairly significant.

8 (Off-microphone comments.)

9 MEMBER VLAHOVICH: We're not going  
10 to go into that.

11 MEMBER BOWMAN: Right.

12 CHAIR MARKOWITZ: Seems to be some  
13 general agreement around this point, so I think  
14 we can probably move on to the next point  
15 unless there are further comments.

16 MEMBER CLOEREN: What do you think  
17 the agreement is?

18 CHAIR MARKOWITZ: Dr. Van Dyke.

19 MEMBER VAN DYKE: I really hesitate  
20 to say this because I'm actually coming around  
21 to the significant incidental, you know,  
22 classification because it is, you know, I think

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1 that the way the statute's written, that's the  
2 only bar is significant or incidental. And  
3 while I still think the frequency and duration  
4 is important, maybe what we're heading towards  
5 is they have to address all the exposures.  
6 They have to cite where they got -- where they  
7 found the information, whether or not it's  
8 significant or incidental. Maybe we need a new  
9 table that's an easier table to address with  
10 just those things. See, I knew that was going  
11 to be difficult.

12 CHAIR MARKOWITZ: Just a comment on  
13 the. I don't think the act says significant  
14 exposure. I think it says that a significant  
15 exposure has to be a significant factor and  
16 contributing, aggravating, or causing. Correct  
17 me if I'm wrong, Ms. Pond. So that word  
18 significant is not attached to exposure, at  
19 least in the act. Just by way of  
20 clarification.

21 MS. POND: I know that it's used --  
22 significant exposure -- I'm sorry, this is

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1 Rachel. It is a significant factor in causing,  
2 contributing to, or aggravating. I don't know  
3 if it's used at all with the exposure, but I'll  
4 double check. I don't think it is. But let me  
5 check and get back to you.

6 CHAIR MARKOWITZ: So, Dr. Van Dyke,  
7 can you just repeat your thought here?

8 MEMBER VAN DYKE: Yes. This is Mike  
9 Van Dyke. So my thought was it's an agreement  
10 that we need to address all the exposures that  
11 are listed in the OHQ as well as what's  
12 identified in the SEM. We need to be able to  
13 say whether each one of those are incidental or  
14 significant. And I think we need to say where  
15 that information came from.

16 Now there will be incidents where  
17 you have something that's identified in the OHQ  
18 that there is no information to corroborate  
19 that or to, you know, provide additional  
20 information. And I think that that information  
21 in itself is probably important to the CMC as  
22 well is that, you know, we looked for this. We

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1       couldn't corroborate this exposure. That says  
2       we looked, you know, there's no information out  
3       there.

4               So what I was proposing is that we  
5       put that into -- I mean a table would be  
6       helpful to be able to say all those things, and  
7       a table could be pretty simple. So that was my  
8       suggestion.

9               I want to add one more thing that in  
10       order to make this -- just tweak it a touch, it  
11       has to be a relevant exposure. So it has to be  
12       some exposure that has been associated with the  
13       disease. So I can foresee this OHQ having, you  
14       know, hundreds of chemicals on it and, you  
15       know, 89 of them are irrelevant to the  
16       particular disease. I don't think that the IH  
17       should have to go through those. So any  
18       relevant chemicals should be put in a table.  
19       And those relevant chemicals are identified  
20       through those relationships in the SEM.

21               CHAIR MARKOWITZ: That strikes me as  
22       complicated to actually do it. So the claims

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1 examiner who is entering the SEM to identify  
2 the exposures, and that person may or may not  
3 be necessarily using the OHQ to do that. So  
4 then the statement of accepted facts, the  
5 claims examiner hands over the relevant  
6 exposures according to their way of looking,  
7 and the SEM to the IH. So it needs to be  
8 workable. So you're suggesting that the IH  
9 look at the OHQ and decide, above and beyond  
10 the statement of accepted facts, which  
11 additional exposures might be relevant? Yeah,  
12 Dr. Van Dyke.

13 MEMBER VAN DYKE: So Mike Van Dyke  
14 again. I'm all right with the claims examiner  
15 doing that. But we have to be very -- it has  
16 to be very clear that they're looking at the  
17 exposures on the questionnaire as well as what  
18 they're identifying on the SEM.

19 CHAIR MARKOWITZ: All right. But --

20 MEMBER VAN DYKE: I don't know -- I  
21 don't know if we could trust that.

22 CHAIR MARKOWITZ: Yeah. But the

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1 problem is I, you know, is the claims examiner  
2 really qualified to decide, above and beyond  
3 the SEM from the OHQ, which are medically  
4 relevant or not? I'd be skeptical about that.

5 MEMBER VAN DYKE: Well, aren't all  
6 the exposure disease relationships -- I mean  
7 most of those are outlined in the SEM, right,  
8 from HAZMAT.

9 CHAIR MARKOWITZ: Right, presumably.  
10 But then you're saying the CE takes the  
11 exposures above and beyond what they found in  
12 the SEM in relation to job title, the exposures  
13 from the OHQ submits them through the SEM to  
14 determine whether they're medically -- whether  
15 they're in the ballpark. And then if they are,  
16 then move them on to the IH.

17 MEMBER VAN DYKE: Seems complicated.

18 CHAIR MARKOWITZ: Yeah. That's what  
19 I was thinking. Yeah.

20 MEMBER FRIEDMAN-JIMENEZ: This is  
21 George Friedman-Jimenez. One comment to  
22 respond to this. I think the flow of events

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1 went from determining what the disease is, and  
2 then from that disease what are the -- what's  
3 the short list of toxic substances that have  
4 been reported to cause that disease. And  
5 usually it's a short list, or none.

6 And so I think that's what Mike is  
7 referring to, and I would agree with that.  
8 That if you have someone with pulmonary  
9 fibrosis, you don't need to be looking at lead  
10 and, you know, a lot of organic solvents.  
11 You're looking at the three main causes of  
12 pneumoconiosis. And so those are the relevant  
13 exposures as defined by the disease and the  
14 disease exposure relationships that are listed  
15 in the SEM.

16 So then the question becomes is the  
17 SEM complete enough? Is it reliable enough to  
18 depend on it for an untrained person like a  
19 claims examiner to make that determination  
20 rather than it having to be made by a CMC or an  
21 occupational physician who is trained in that?

22 So I think it could be made into a

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1 simple workflow where the disease is identified  
2 first, and then the exposure that's -- the  
3 exposures that are relevant to that disease are  
4 defined by what is known -- what's the science  
5 that's known about the causation of that  
6 particular disease and toxic substances. So  
7 then we get down to what is the -- how good is  
8 the SEM for that use so that -- I'd like to  
9 know what people think about that.

10 CHAIR MARKOWITZ: Dr. Cloeren.

11 MEMBER CLOEREN: This may not be --  
12 this is an interesting example, I may be coming  
13 around to what George is saying. If you look -  
14 - if you look up beryllium, and I know that we  
15 have a test that lets you know there's  
16 somebody's sensitized to beryllium so that  
17 makes it kind of easier. But if you look up  
18 construction workers in relation to beryllium,  
19 you don't find that they're exposed to it. And  
20 we've got plenty of construction workers in the  
21 BTMed program that have beryllium sensitivity  
22 and, you know, several with chronic beryllium

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1 disease as well.

2 So relying on the SEM to identify --  
3 like they were exposed somehow, right? And  
4 there's increased risk at certain sites, you  
5 know, and that, you know, there's other  
6 evidence. You know, I don't think it's -- it's  
7 not a routine exposure for construction workers  
8 outside of DOE. But it's not reflected for  
9 that job in the SEM.

10 And so relying on the SEM to come up  
11 with potential associations for -- Beryllium is  
12 a pretty good example of something that where  
13 an incidental exposure, you know, could wind up  
14 causing disease down the road because it's not  
15 the classic dose response. So I'm not sure how  
16 to handle it, but I thought I'd share that  
17 example.

18 CHAIR MARKOWITZ: Yeah. Yeah. I  
19 don't see either the claims examiner or the  
20 industrial hygienist making a judgment about  
21 the medical relevance of potential exposures.  
22 I mean I think to keep it straight forward,

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1 that we should recommend the industrial  
2 hygienist look at the OHQ, and if there are  
3 exposures they consider to be important, that  
4 they be included in the table. And that be  
5 passed along to the CMC, and the CMC decides  
6 the medical relevance.

7 Otherwise, we're in a circular  
8 situation where the SEM has undue importance in  
9 determining medical relevance. And the whole  
10 point of the OHQ is to get beyond the SEM to  
11 understand what the person was really exposed  
12 to. Dr. Cloeren.

13 MEMBER CLOEREN: So I think we're in  
14 agreement on kind of the principles of our  
15 response. What I think still needs to be  
16 worked out is kind of how the process might  
17 work, I mean the flow. I mean a lot of that is  
18 up to the Department to figure out. But we  
19 also don't want to be recommending something  
20 that is like totally impractical.

21 So the table may be hanging us up a  
22 little bit where I think that we are in

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1 agreement about addressing the elements in the  
2 OHQ. We are in agreement with sharing the OHQ.  
3 I think we are in agreement about stating what  
4 data was found in each of the different sources  
5 that were reviewed or not found, you know,  
6 explicitly. So I think that, you know, we have  
7 overall agreement about that. It's mostly the  
8 table idea that I think is hanging us up.

9 CHAIR MARKOWITZ: Yeah. We  
10 definitely -- it's not our job to get into, you  
11 know, how this might be implemented, right? I  
12 mean we -- on the hand, we shouldn't recommend  
13 something that's totally unworkable, right?  
14 But we definitely don't have to get into the  
15 weeds about that because that's what the  
16 program does, so. But I would agree with you,  
17 what you say. Comments, questions?

18 MS. POND: I do have that definition  
19 if you want it. It's in 7385(s)(4) in the  
20 statute. It says, "Department of Energy  
21 contractor employees shall be determined for  
22 purposes of this part to have contracted a

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1 coverage on this through exposure at a DOE  
2 facility if, A, it is as least as likely as not  
3 that exposure to a toxic substance at a  
4 Department of Energy facility was a significant  
5 factor in aggravating, contributing to, or  
6 causing the illness; and B, it is as least as  
7 likely as not that the exposure to such toxic  
8 substance was related to employment at a DOE  
9 facility."

10 CHAIR MARKOWITZ: Right. Yeah. And  
11 I think Ms. Hand, who is sometimes here in the  
12 audience, who's not here today. Maybe she's  
13 listening. But she has repeatedly pointed this  
14 out to the Board over the years, this  
15 distinction between significant exposure and  
16 significant factor. The act says significant  
17 factor, so. So what else do we have, Dr.  
18 Cloeren, on this? Yeah. Or we're ready to  
19 assemble? Okay.

20 MEMBER CLOEREN: All my cards are on  
21 the table.

22 CHAIR MARKOWITZ: Okay. So let's

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1 move on, and there should be a PowerPoint that  
2 says Markowitz. So the Board made a  
3 recommendation last time, and I have an excerpt  
4 of that recommendation. I don't have the -- I  
5 didn't put the rationale on a slide, so if we  
6 need -- if we need to revisit the rationale, we  
7 can just discuss it.

8 But I highlighted the key phrase  
9 that we recommended that the program develop a  
10 mechanism to evaluate the validity and accuracy  
11 of the opinions and rationales expressed by the  
12 CMC in their reports. Then we went on to say  
13 that it should be done in a way that respects  
14 conflict of interest with, you know, the  
15 parties that are currently responsible for the  
16 CMC reports. And so this was not accepted by  
17 the program, and if we could go to the next  
18 slide.

19 So this is excerpts from the  
20 departmental response, and in order to fit it  
21 on a slide, I just really took kind of the key  
22 words or key elements of that. First, the

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1 current adjudication procedures provide claims  
2 examiners with the necessary guidance to assist  
3 the weight of medical evidence in determining  
4 the validity and accuracy of medical opinions  
5 submitted by a CMC.

6 And then, above and beyond that,  
7 there are additional program safeguards. First  
8 the CEs are required to demand additional input  
9 from the CMC when the rationale or the  
10 foundation for their analysis is found to be  
11 insufficient by the CE.

12 Secondly, the program has clearly  
13 defined mechanisms to assure quality and  
14 accuracy. And third, that, actually, the  
15 program has staff who are dedicated solely to  
16 assessing quality assurance including,  
17 presumably, this issue of CMC. And the risk of  
18 another layer of review is that it would lead  
19 to duplication and delay. So if you can go to  
20 the next slide for a moment.

21 And then at the end, then, the  
22 Department requests that the Board provide

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1 specific guidance or references. I want to --  
2 I want you to pay attention to this text  
3 because I need some help here understanding  
4 this. To medical health science data that can  
5 be communicated to staff or CMCs about medical  
6 standards or epidemiologic data that could  
7 serve to eliminate or reduce instances of gross  
8 errors. That was the term that we had used in  
9 our rationale as mentioned by the Board.

10 So the request to us is that we  
11 identify guidance or references to medical  
12 health science data that they could use to  
13 communicate to staff, to CMCs concerning  
14 medical standards or epidemiologic data that  
15 can serve to eliminate or reduce instances.

16 So I don't want -- I want to get to  
17 this because -- not right away, I want to go  
18 back and look at the other elements of their  
19 response. But I do want to get to this because  
20 I don't -- yeah, I have my own opinion about  
21 this, which I'll express in a moment. But next  
22 slide.

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1           Okay. So let's back up two slides  
2 if we could. Okay. So the first point is that  
3 there are procedures in place that provide CEs  
4 with the necessary guidance to assess weight of  
5 medical evidence in determining validity and  
6 accuracy. So I understand this to mean that we  
7 have in the procedure manual, and maybe  
8 otherwise, but in the procedure manual  
9 presumably, some specific directions to the  
10 claims examiner in order for them to determine  
11 whether the CMC is producing a valid and  
12 accurate opinion. And I want to discuss what  
13 these procedures are.

14           I think the question is whether they  
15 achieve what is purported to achieve here. But  
16 just to, again, review the one, two, three  
17 point, CEs are required to demand additional  
18 input when the CMC, the rationale, or  
19 foundation is insufficient. So that's a good  
20 thing, right, if a CMC produces a report and  
21 it's clearly inadequate, that they give the CMC  
22 another chance to actually beef up their

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1 reports so that, you know, it's well  
2 rationalized.

3 And then the program has clearly  
4 defined mechanism, but I think actually this,  
5 in part, refers back to these adjudication  
6 procedures, and in part to the quality  
7 assurance program. And then the idea that they  
8 have staff dedicated to quality assurance,  
9 which is a good thing, but I don't think those  
10 staff -- and you can correct me if I'm wrong  
11 here, I don't think we're talking about  
12 healthcare providers who are doing that quality  
13 assurance exercise. I don't think it's being  
14 done by physicians or other healthcare  
15 providers. They're analysts in the policy  
16 branch who are doing the quality assurance,  
17 this part, and other parts of the quality  
18 assurance. So let's go ahead two slides.

19 And at some point, I realized in  
20 looking at this and trying to understand how  
21 the program views this and how we view this is  
22 that I think actually we have different ideas

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1 about what accuracy and validity are. Like I'm  
2 basically wondering did the CMC get it right.  
3 Given the facts, did their interpretation,  
4 their opinion they expressed, is it correct?  
5 Or within a range of acceptable  
6 interpretations? It may not be exactly what I  
7 think for instance, but is it within the range  
8 of reasonable doctors would agree or disagree  
9 about it? Or is it outside that and they're  
10 just plain -- they're just wrong? I mean it  
11 happens, right?

12 And so that's what I think about.  
13 But I don't think that's the way the -- at  
14 least in the description I could find the way  
15 the program really zeros in on quality and  
16 validity. So from the procedure manual, Page  
17 129, specifically, a well-rationalized  
18 causation opinion, and that's what the CMC is  
19 supposed to produce, you know, that's what the  
20 -- that's what the product is, from a qualified  
21 physician. By the way, it can be produced by  
22 the personal physicians, but we're really

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1 talking here about the CMC report.

2 It communicates accurate  
3 understanding of the employee's toxic substance  
4 exposure, discusses in the employee's medical  
5 history pertinent diagnostic evidence, and then  
6 applies reasonable medical judgment informed by  
7 relevant, credible medical health science  
8 information.

9 So the CMC is required to apply  
10 reasonable medical judgment. So who's in the  
11 position of determining whether the CMC is  
12 applying reasonable medical judgment? And,  
13 frankly, can non-healthcare providers really  
14 make an accurate assessment of whether what the  
15 CMC is saying is a reasonable medical judgment?

16 And it's supposed to be backed up by  
17 references by medical health science  
18 information. Presumably, those are references  
19 in the report, right, and we've seen them. We  
20 seem the in the IH report. Frankly, the claims  
21 we've seen, a lot of the references that we've  
22 seen in these reports are extremely generic. I

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1 mean we saw it again in the fictitious IH  
2 report that they sent us in relation to the I  
3 have. There are textbooks, there are a variety  
4 of sources that aren't specific to a particular  
5 case or exposure. Anyway, next. So that's  
6 what the procedure manual says.

7 And then to go on, this is -- now  
8 these are the instructions for the claims  
9 examiner, and I'm almost finished with my  
10 little monologue here, so. But instruction to  
11 the claims examiner, and I picked out I think  
12 the most relevant part. If anybody wants to  
13 see the context, we can just bring up the  
14 procedure manual, Page 137, and see the other  
15 elements.

16 So a well-rationalized opinion,  
17 well, the claims examiner is supposed to prefer  
18 the following: A well-rationalized opinion  
19 over one that is unsupported. Rationalized  
20 means supported by an explanation of how the  
21 conclusions are reached, including appropriate  
22 citations or studies. We just discussed that.

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1           And the well-rationalized is a  
2           convincing argument that is reasonably  
3           justified -- represents a reasonably justified  
4           analysis of relevant evidence. And then it  
5           gives an example of where an opinion that is  
6           supported by interpretation of diagnostic  
7           evidence, relevant and scientific medical  
8           literature is well-rationalized. If it's not,  
9           then the conclusion that's reached is not well  
10          rationalized. And next slide. And this may be  
11          the last slide I have.

12           Okay. So we can back up. So my  
13          problem with all this is that the quality  
14          assurance procedures for CMC reports relate to  
15          timeliness of the report. These are the  
16          requirements of the contractor, the CMC  
17          contractor. The timeliness of the report,  
18          whether it has a well-rationalized argument in  
19          the report, whether it faithfully reflects the  
20          facts of the case, whether it appropriately  
21          addresses the statement of accepted facts, and  
22          some other elements of the report.

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1           But unless I'm missing something,  
2 what I don't see is this head-on determination  
3 about whether the well-rationalized argument is  
4 actually correct or not. And the reason why  
5 it's important is when we did review claims  
6 over the years, that there were some, a small  
7 proportion I would say somewhere 10 and 20  
8 percent, in which the CMC report was just plain  
9 off.

10           And it was striking because it was a  
11 shame. You know, the person was not going to  
12 get compensated because, you know, it was the  
13 CMC to do the report. And the procedures, the  
14 system had no way of catching that. They could  
15 catch it if the report was late, if it was  
16 absent of any argument, if it didn't have  
17 references, and other aspects of the appearance  
18 of the report. But the actual judgment itself  
19 that there wasn't a head on analysis of that.

20           Now I think there used to be because  
21 going back a few years, I think it's true that  
22 the physician associated with the program did

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1 quarterly assessments of CMC reports,  
2 impairment, causation, and the like. And then  
3 would look at that issue of causation. But  
4 they rarely found any problems, and I think --  
5 personally, I think the issue here -- and they  
6 frequently found problems with the impairment  
7 reports, about 20 percent of the time. Some of  
8 you may remember that when we looked at that  
9 because we've looked at that previously.

10 But I think they rarely found  
11 causation problems because OccMed people around  
12 the table understand this, but others should  
13 understand, too, within occupational medicine,  
14 there are various niches and, you know, I'm not  
15 an impairment evaluator so you wouldn't send me  
16 an impairment. You wouldn't have me go be a  
17 corporate medical doc for a company because I'm  
18 clueless about what they do. You wouldn't ask  
19 me to do supervised drug testing because I  
20 don't know anything about that. But if it  
21 comes to a question like epidemiology or  
22 causation, then, you know, we want Dr.

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1 Friedman-Jimenez because that's what he does in  
2 life, right?

3 And there are these separate niches  
4 in occupational medicine that people specialize  
5 in or not. And so I think what's going on, in  
6 part, is there's some CMCs who this is not  
7 really their expertise, but they get -- they're  
8 placed in a position of doing causation  
9 reports. And that it seems like a problem that  
10 is detectable and addressable. End of my  
11 monologue. Dr. Cloeren.

12 MEMBER CLOEREN: This is all so kind  
13 of hypothetical. I want to give a case example  
14 that I think everybody could probably relate  
15 to. We saw a case of somebody that had  
16 asbestos exposure and had interstitial lung  
17 disease consistent with asbestosis ,and the CMC  
18 in the determination that there was not a  
19 causal relationship made the statement that you  
20 can't have asbestosis without pleural plaques.

21 And so that was kind of like a  
22 statement of -- an incorrect statement stated

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1 as if it was a medical fact, and it's a common-  
2 enough condition that it might be one where the  
3 claims examiner might have thought to  
4 themselves, wow, you know, I've already  
5 adjudicated a bunch of claims of asbestosis  
6 without plaques, you know, were those wrong.

7 But I think if the requirement is  
8 that the CMC back up statements like that, that  
9 would at least maybe cause the CMC to look up,  
10 you know, what proportion of asbestosis cases  
11 show up without pleural plaque, and maybe that  
12 would be useful. Maybe requiring something to  
13 back them up because I think that's a really  
14 blatant one where I think we can all agree  
15 that's a problem.

16 CHAIR MARKOWITZ: But there is  
17 currently a requirement that the well-  
18 rationalized argument be supported by reference  
19 to the medical health science literature.  
20 That's in the current procedure.

21 MEMBER CLOEREN: I don't think this  
22 one has --

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1 (Off-microphone comments.)

2 CHAIR MARKOWITZ: Well, I think --  
3 you're probably a little bit more hopeful about  
4 the amount of time that you think that doctor  
5 will put into that question than I am. But --

6 MEMBER CLOEREN: I think that this  
7 CMC, this is a belief by this CMC that is  
8 probably used time after time after time in  
9 that CMC's report, and there ought to be a way  
10 to counter that kind of like misinformation  
11 that is shared, which I think is rare. I don't  
12 think it's not the norm by any means. But it's  
13 something that there ought to be some kind of  
14 way to address, and I don't know what that is,  
15 but.

16 CHAIR MARKOWITZ: Comments, ideas?

17 MEMBER CLOEREN: So actually did see  
18 that twice by the same CMC in two different  
19 claims, that's why I think it might --

20 CHAIR MARKOWITZ: Yeah.

21 MEMBER CLOEREN: -- a pattern.

22 CHAIR MARKOWITZ: And you didn't

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1 review that many claims, right?

2 MEMBER CLOEREN: No.

3 CHAIR MARKOWITZ: Yeah. Yeah. Dr.  
4 Bowman, you look like you want to say  
5 something. Sorry. You just have that look on  
6 your face. Dr. Friedman-Jimenez?

7 MEMBER FRIEDMAN-JIMENEZ: Well, you  
8 know, what's making this difficult is that  
9 there's no gold standard. It's not like, you  
10 know, a blood lead level that you can measure  
11 whether you're right or wrong. Now there's an  
12 element of judgment that is necessarily  
13 involved in these determinations. And so I  
14 think it's not a simple thing, and it has to  
15 be, I think, accompanied by some set of  
16 presumptions of exposure and of causation that  
17 claims examiners can apply who are not trained  
18 in making these judgments at a medical level.

19 But it also has to include detailed  
20 causation analyses by occupational physicians  
21 who are trained in that subset of cases for  
22 which there are complicating factors, or it's

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1 not a clear cut exposure, it's not a clear cut  
2 diagnosis, et cetera.

3 So I think that we should really  
4 discuss this further. And, you know, I would  
5 propose that we have a working group to focus  
6 on the causation assessment. You know,  
7 certainly the exposure assessment is a major  
8 part of this. That's actually probably the  
9 weakest link. But I think there's a separate  
10 causation assessment that needs to be done that  
11 can be done in some cases by presumption in the  
12 extreme cases where it's a clear cut case, but  
13 which also needs to be done very analytically  
14 by trained occupational physicians, and  
15 hopefully then in the minority of cases where  
16 it's not so clear cut.

17 So I think that we do need to  
18 discuss this more. I think that we need to  
19 come up with a workable set of recommendations  
20 for streamlining this causation assessment in a  
21 way that's practical and that can be applied.  
22 And I don't think we're there yet, and I don't

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1 think we have time at this meeting to make that  
2 recommendation. So I think a working group  
3 could address this.

4 CHAIR MARKOWITZ: I would say --  
5 Steve Markowitz. I would say on the  
6 presumption front that the Board has provided  
7 advice to the program on presumptions in  
8 several areas over the years, and those have  
9 been largely accepted by the program. And if  
10 there are other issues that are ripe for  
11 presumptions that we should or the program  
12 wants us to look at, that we should address  
13 them because presumptions are very helpful to  
14 the program. But I haven't been able to think  
15 of any additional areas that we might help them  
16 develop presumptions for.

17 And so this really involves the non-  
18 presumption cases, right, the ones where you're  
19 looking at all the individual information and  
20 then trying to make a decision. You know,  
21 the -- so on this slide now, the Board is  
22 requesting that -- or excuse me, the Department

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1 requests the Board provide specific guidance or  
2 references, medical health science data to be  
3 communicated to CEs or CMCs about medical  
4 standards or epidemiologic data.

5 I can't think of any way to do that.  
6 I can't think of any textbook, database, or a  
7 set of medical consensus documents, joint  
8 statements that would fulfill that purpose. I  
9 don't think it exists. And, you know, we can  
10 go into the reasons, but regardless. So I  
11 don't think there's any way really of complying  
12 with this request. But maybe other people have  
13 ideas. Dr. Bowman.

14 MEMBER BOWMAN: Steve, I agree with  
15 your assessment there. I used PubMed to look  
16 up if there's review articles on causation  
17 assessment with exposures to toxins and  
18 occupational health. And the only examples I  
19 could find are very specific to specific toxins  
20 directly with specific disease. And so the  
21 library of such articles that would be relevant  
22 would just be too vast to be something that we

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1           could respond to.

2                       But a second thing, going back to  
3 what you said earlier about you'd want to ask  
4 the right person for the opinion because of the  
5 nature of specialization in OccMed, and that's  
6 true for scientific fields as well. And I was  
7 thinking I don't know and maybe the Department  
8 can tell us, maybe someone on the Board knows,  
9 how is CMC expertise taken into account or not  
10 in selecting which CMC evaluates a case?

11                   CHAIR MARKOWITZ: Well, I can just  
12 give an initial response, and if I'm wrong, the  
13 -- they try to pick the medical discipline  
14 that's most relevant to the questions of the  
15 claims examiner. So could be orthopedic, it  
16 could be pulmonary. It could be cancer,  
17 oncology. It could be occupational medicine or  
18 the like. And they try to match it up. I  
19 think the contractor's obligation is to try to  
20 match up what the questions are with the  
21 relevant discipline. Did I get that right?

22                   MS. POND: Yes, that's correct.

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1 CHAIR MARKOWITZ: Dr. Van Dyke.

2 MEMBER VAN DYKE: Mike Van Dyke. So  
3 I'm, you know, sitting here thinking about this  
4 with no gold standard, this is the art of  
5 medicine, right? I mean this is that undefined  
6 part that you have to put all those pieces of  
7 information together to get the right answer.  
8 And I'm skeptical that there's any way to do  
9 that given the breadth of the conditions and  
10 the breadth of the exposures because it's going  
11 to be a little bit different for many of them.

12 So I don't have a great answer for  
13 you. But I don't know if we have a good answer  
14 on the size of the problem either. So I think  
15 that if we could get some information around,  
16 you know, denial of claims and reasons they're  
17 denied in some sort of way that we could say,  
18 you know, 10 percent of claims are denied based  
19 on inability of the CMC to establish causation,  
20 you know, then at least we know it's 10 percent  
21 that we're looking at and it's not 50.

22 So I think that would be helpful as

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1 a start. And then we might be able to dig into  
2 some of those because we might be able to  
3 identify specific diseases or specific  
4 exposures where you're consistently seeing more  
5 problems than others. But as a holistic  
6 problem, I'm a little skeptical that you can  
7 find a good answer.

8 CHAIR MARKOWITZ: The Department has  
9 provided for us, I think at two separate times,  
10 tables on the most common health conditions for  
11 which there are claims by organ system or  
12 sometimes by disease type, cancer. And then  
13 the number of claims in a given time period,  
14 how many were accepted, how many were denied,  
15 and then the reason for the denial, and it  
16 could be any number of things. Causation's one  
17 of them. But there are other reasons as well,  
18 ineligible and this and that.

19 And so it would be helpful to have  
20 an update on that table, actually, since the  
21 last one that was provided to us. Probably  
22 it's only a year's worth of data, but it would

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1 be of interest. It may also be of interest  
2 relevant to the fluctuation in the number of  
3 claims.

4 I don't think that's going to answer  
5 the question because it tells you sort of the  
6 outer limit of the problem. But all you have  
7 is the percentage of claims that are denied by  
8 virtue of ineligibility or no employment  
9 verification or causation. And then within  
10 that, a lot of those causation opinions are  
11 going to correct, right? And then some portion  
12 are incorrect, and those are the ones we're  
13 worried about. But it'll give you some sense  
14 of magnitude of the problem. So I think we  
15 should request that and that might help the  
16 discussion.

17 But I mean to say about -- let me  
18 just respond to the art. I actually don't  
19 think this is a question of art. I think these  
20 are cases in which, you know, the doctor made  
21 the incorrect conclusion based on what we know  
22 about the medical science. And it wasn't a

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1 question of art at all. It was a question of  
2 science, and they just got it wrong. And, you  
3 know, we can talk about the gold standard in a  
4 minute because it's not like I consider myself  
5 to be the gold standard. It sounds like it,  
6 but it's not. But, you know, there, you know,  
7 sometimes doctors are wrong, right? Dr.  
8 Cloeren.

9 MEMBER CLOEREN: What if in a few  
10 cases it's not about the art of science, but  
11 about bias of a particular CMC, or one or more?  
12 I wonder if the Department has ever looked or  
13 would think about looking at the kind of trends  
14 among CMCs in agreeing with, like, saying yes,  
15 caused and no, didn't to see if there's any  
16 bias in a particular direction.

17 MS. POND: This is Rachel. Yes, we  
18 have looked at that after some of the Board  
19 actually reviewed some cases and had brought  
20 some things to our attention. So we have  
21 looked at those trends to a certain extent.  
22 You know, we didn't find anything really

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1 significant. I think there may have been one  
2 or two that we kind of had to look at more  
3 closely and talk to the contractor about.

4 But, in general, we didn't see  
5 anything specifically that would lead us to  
6 believe there was a particular bias other than  
7 there might be trends like you found in the one  
8 report about, well, this doctor consistently  
9 says this. And the trouble with claims  
10 examiners, they can weigh medical evidence, but  
11 they can't know if the medical veracity is  
12 wrong necessarily.

13 And that's where I think Dr.  
14 Markowitz is talking about that complication  
15 for us because we have to weigh the medical  
16 evidence, and we have to look at the quality of  
17 these reports. But different doctors at  
18 different times are going to say I don't agree  
19 or I do agree, and that's where we get into  
20 this kind of rub as to figuring out when it's  
21 the report that's just wrong and how we would  
22 know that as claims staff.

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1           So our claims staff do the best they  
2           can in trying to look at the various opinions.  
3           Actually read through the references that are  
4           provided because we get these reports, not just  
5           from CMCs, but we're not getting a lot of them  
6           from treating physicians, authorized reps  
7           physicians that, you know, have been providing  
8           these reports.

9           So we have to shift through them in  
10          all those facets to review the references, are  
11          they relevant? Do they make sense to this  
12          actual situation? So it is a very complicated,  
13          as you all know, problem to have, and looking  
14          at the whether it's right or not in the face of  
15          it, the medical veracity of it, that's where we  
16          struggle and that's why we're where we are, I  
17          believe, with this topic.

18                   CHAIR MARKOWITZ: Dr. Vlahovich.

19                   CHAIR MARKOWITZ: Kevin Vlahovich.  
20           Similar to what Dr. Cloeren was just talking  
21           about, about whether a CMC is the appropriate  
22           person to review a study, or if there's bias

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1 present. Even in the example that Dr. Cloeren  
2 gave about someone having no pleural plaques,  
3 but asbestosis. I'm sure that if you looked up  
4 PubMed, you could probably find some studies  
5 that will say that is true, you know, when the  
6 99 percent of these might not.

7 Is there a way when reviewing  
8 evidence that has been cited to verify the  
9 accuracy or veracity of that? Like what impact  
10 study, the journal cited, or what types of  
11 studies have been cited, whether it's  
12 systematic review or case study? And I don't  
13 know if there's an answer to these questions,  
14 but --

15 MS. POND: Yeah. I don't know if  
16 that was necessarily a question for me. This  
17 is Rachel. I'm sorry. But in terms of when we  
18 do look at the citations that are provided, if  
19 we have -- if our claims staff have questions,  
20 or they say this seems kind of right but  
21 they're not sure, they'll go to the  
22 toxicologist oftentimes to provide us with some

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1 more information about those articles of what  
2 they mean and try to give us some  
3 interpretation.

4 If there's a question that, you  
5 know, we can re-ask, go back to the doctor  
6 whether it's a CMC or the treating doctor,  
7 we'll do that and say we're not really sure  
8 what this means or where this comes from, we  
9 can do that. But that's where knowing when to  
10 ask those questions, when not to ask those  
11 questions becomes a challenge.

12 CHAIR MARKOWITZ: If we looked again  
13 at this slide about whether the Board can help  
14 find guidance, references, medical health  
15 science data, medical standards, or  
16 epidemiologic data, so, you know, I can think  
17 in the cancer field, if we're talking about  
18 oncology, how to do that, you know, you would  
19 go to the standard of care set out by the  
20 National Comprehensive Cancer Network, NCCN.  
21 They have treatment recommendations. And you  
22 can, if you were diagnosed with cancer,

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1       whatever type of cancer, that's where the  
2       oncology community would agree, kind of a  
3       starting place for what treatments you give.  
4       And these are consensus treatment  
5       recommendations.

6               We don't have anything like that in  
7       occupational medicine. We don't have a  
8       textbook like that. We don't, you know, have a  
9       set of guidance documents or -- can anybody  
10      think of any response to this request from the  
11      Department that might be helpful?

12             MEMBER FRIEDMAN-JIMENEZ:       Yeah.  
13      This is George Friedman-Jimenez. I've reviewed  
14      a small number of cases, and I would say I  
15      agreed with most of the causation analyses.  
16      But I saw several that I disagreed with, and  
17      that I think were in error. And in both  
18      directions, both denying causation when I  
19      thought that it was likely, and in one or two  
20      cases supporting causation when I thought it  
21      was not likely, which we didn't make an issue  
22      because we didn't want to overturn a settled

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1 case. But I think those are in the minority,  
2 but it does occur in both ways.

3 And I think that there are some ways  
4 that we could identify implementable  
5 recommendations that would reduce the  
6 likelihood of these kinds of misinterpretations  
7 that lead to this likely errors. And I say  
8 likely errors because I'm not, you know, a gold  
9 standard either. These would be disagreements  
10 among physicians.

11 But I think we could improve on some  
12 of the literature reviews. They could be  
13 updated that are done to support some of the  
14 decisions. We could improve on understanding  
15 of multiple factors contributing to causation.  
16 There are a number of ways that we could  
17 improve on the accuracy of these causation  
18 determinations, and I think it would be worth  
19 looking at them.

20 And, you know, we're not going to  
21 solve the entire problem, and, in fact, we  
22 don't have a gold standard, as I said. And so

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1 we're never going to be able to measure the  
2 sensitivity and specificity exactly of the  
3 causation determination compared to the actual  
4 truth.

5 But we can, you know, use the  
6 expertise of toxicologists, of industrial  
7 hygienists, of epidemiologists and clinical  
8 occupational physicians to come up with a best  
9 judgment in some cases that would differ from  
10 the judgment of a single CE or a CMC that made  
11 a determination that was based on either  
12 misinterpretation of data or not considering  
13 some of the available information on exposure  
14 or other disease-related factors.

15 So I think that there is some room  
16 for improving the accuracy of these  
17 determinations, and I think it would be worth  
18 reviewing that and seeing what we can suggest  
19 that would be practical and likely to make  
20 incremental improvements. Again, we're not  
21 going to completely eliminate errors in  
22 causation judgements, but I think we can make

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1 some improvements based on the small number of  
2 cases I've seen.

3 Now many of you have seen a lot  
4 more -- reviewed a lot more cases than I have,  
5 and so I'd be interested to know what you  
6 think, if you've seen causation analyses that  
7 you think are incorrect or that there's some  
8 clear error that was made that could be avoided  
9 in future cases.

10 CHAIR MARKOWITZ: Well, one idea of  
11 approaching this would be kind of in parallel  
12 with the way that the program currently does  
13 quality assessment where they take a certain  
14 number of cases, a certain number of claims.  
15 Right now I think it's about 50 per quarter,  
16 and they're divided equally among different  
17 types of medical reports.

18 Some of them are CMC reports.  
19 Others are what are called file review reports  
20 and other types of reports. And those are  
21 reviewed by the dedicated policy analyst staff  
22 for various aspects of quality that we talked

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1 about before, but not directly head on is this  
2 opinion correct or not.

3 And why not develop a small panel of  
4 causation physicians, that's what their  
5 expertise is, occupational medicine, but this  
6 is what they specialize in, who would  
7 participate in that quarterly assessment? And  
8 what their job would be would be to look at the  
9 causation claims, but the same could be applied  
10 to impairment, you know, impairment  
11 specialists, right, who look at the impairment  
12 claims. And look at whether, you know, look at  
13 whether it's valid, whether the opinion was  
14 valid or not.

15 And if there's a disagreement with  
16 the CMC, then you might hand it over to a  
17 second causation physician sort of as the  
18 referee, right, so that you're not wholly  
19 relying on a single person and their own set of  
20 knowledge, et cetera.

21 But to identify a small panel that  
22 could do this on a quarterly basis. It could

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1 be, you know, I mean I don't know of the  
2 mechanism. Could be embedded I suppose within  
3 the current contract, CMC contract a separate  
4 panel of causation physicians within that  
5 contract, or the Department could do it itself,  
6 you know, that's a mechanism that's up to them.

7 And it would be an improvement on  
8 what there is now because it would be a direct  
9 assessment about whether the causation opinion  
10 was correct or not. And it would be a way of  
11 identifying certain CMCs who are repeat  
12 offenders because if you looked at a certain  
13 number of claims over time, you could see  
14 whether there are people who, you know,  
15 frankly, they shouldn't be doing the CMC  
16 evaluations. It's just not their -- it's not  
17 their strength.

18 So identify the rate of the problem,  
19 monitor that, and it could help identify some  
20 CMCs who, perhaps, shouldn't be part of the  
21 process. So that strikes me as maybe  
22 ambitious, but doable in terms of the way the

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1 Department approaches quality assurance now.  
2 And having achieved unanimous consensus with  
3 this idea. No, seriously, people have any  
4 thoughts or reactions, or --

5 MEMBER BOWMAN: Steven. This is  
6 Aaron Bowman. I agree with what you just  
7 mentioned, and I think your use of the word  
8 consensus earlier is an important part of why I  
9 agree. Right? Like in the scientific  
10 community, we'll assess the quality of data  
11 being presented and whatever by a peer review  
12 process. So there is no, quote, "Gold  
13 Standard." Therefore, the standard is the  
14 consensus of the community.

15 So having other CMCs or relevantly  
16 trained experts to look at this, I would be --  
17 I think, in fact, is the gold standard of how  
18 you assess right or wrong. And if something  
19 can be tied in with existing QA processes and  
20 procedures, that would be good as well.

21 CHAIR MARKOWITZ: So peer review is  
22 the --

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1 MEMBER BOWMAN: Mm-hmm.

2 CHAIR MARKOWITZ: -- right, is the  
3 mechanism essentially? Right. Yeah. Other  
4 comments or -- okay. Well, Dr. Cloeren.

5 MEMBER CLOEREN: I think that sounds  
6 like a great idea. I suspect the problem is  
7 not as big as we may, you know, I think that,  
8 you know, when I used to federal worker's comp  
9 case management, you know, the cases that were  
10 going bad were the ones that I saw. And so  
11 like you get this skewed idea that everything's  
12 gone bad, and that's not the case. Almost, you  
13 know, almost everything is going well.

14 And so having a systematic peer  
15 review process would be helpful in documenting  
16 kind of the degree of the problem, and come up  
17 with some solutions, you know, to it if  
18 problems are identified. I think that's a good  
19 idea.

20 CHAIR MARKOWITZ: Yeah. It may not  
21 be, you know, we don't know, really, the  
22 magnitude. But the point is that the program

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1 cares a lot about quality assurance. You know,  
2 it went through a redesign of quality assurance  
3 of many aspects of many actors in the whole  
4 process. And this is an omission, and it's an  
5 omission that can be rectified. So it's not a  
6 special effort, I think. It's just to fill out  
7 or complete the quality assurance process. And  
8 Ms. Pond is nodding her head yes, so I think we  
9 can move on.

10 MS. POND: I don't think I did that.

11 CHAIR MARKOWITZ: Oh, maybe she was  
12 thinking about something else. George, I was  
13 making a joke, just to be clear. Okay. Okay.  
14 So we've exhausted that for the moment. We can  
15 come back to it tomorrow morning if we want.  
16 But we've exhausted that for the moment. If  
17 there are any last comments or questions about  
18 this, otherwise we'll move on.

19 Okay. Okay. Speeding along here,  
20 are we ready to revisit the significance  
21 question, or should we take a little bit of a  
22 break at this point and -- okay. I hear two

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1 nods in favor of breaks. So we're going to  
2 take -- it's 2:20, let's reconvene at 20 of  
3 3:00, in 20 minutes.

4 (Whereupon, the above-entitled  
5 matter went off the record at 2:20 p.m. and  
6 resumed at 2:43 p.m.)

7 CHAIR MARKOWITZ: Okay, let's get  
8 started again. So the schedule for this  
9 afternoon, we've got one more topic, actually,  
10 to address by our agenda, and then we have the  
11 public comment period. So, as it stands now,  
12 we have no people requesting to make public  
13 comments, but the Board needs to be available  
14 at 4:15 in case anybody does come forth.

15 And let me just say for the public,  
16 to the extent the public is participating in  
17 this, you're welcome to make a public comment  
18 starting 4:15. The way in which you would  
19 communicate your desire to make a public  
20 comment would be, Ryan?

21 MR. JANSEN:

22 [Energyadvisoryboard@dol.gov](mailto:Energyadvisoryboard@dol.gov). Just send a

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1 message to that email address and we will put  
2 you on the list.

3 CHAIR MARKOWITZ: Okay, so now we're  
4 going to return to a topic that the Board  
5 discussed at a meeting or two ago about some  
6 language from the procedure manual relevant to  
7 what we were discussing before, which is  
8 basically different levels of exposure that  
9 industrial hygienists can estimate for use in  
10 claims evaluations. So what I've done is  
11 actually bring up from the procedure manual the  
12 part, page 127, procedure manual 7.1, which  
13 deals with this, but let me turn it over to Dr.  
14 Cloeren.

15 MEMBER CLOEREN: Okay, well I think  
16 everybody can see it. This is just kind of a  
17 quick review, I guess, that the levels -- so  
18 I'll just read parts of it. The IH will assign  
19 a level of exposure to each toxic substance as  
20 incidental, significant or more than  
21 incidental, but less than significant. I think  
22 there's kind of implied in there or none,

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1 right?

2           So, if there's an exposure it's  
3 incidental, significant, or more than  
4 incidental but less than significant and then  
5 within -- well, I guess we could look at what  
6 incidental is. It's generally kind of in  
7 passing, intermittent, infrequent. Thank you,  
8 that's helpful. And, usually without a  
9 connection to their normal work.

10           Significant, then, is further broken  
11 down into three potential categories - high,  
12 moderate or low. So this would be for each  
13 exposure that's relevant. Then, in  
14 categorizing it, they take into account their  
15 job classification, their work tasks, the  
16 presence or absence of exposure monitoring  
17 data, and I think that's actually really  
18 important that that's in there. They take that  
19 into account and I'm sure that weighs into  
20 their decisions, but the reports don't tend to  
21 be explicit about what is available about  
22 exposure monitoring.

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1                   Frequency of activities, and I think  
2 a lot of what the industrial hygienist does, I  
3 believe, is makes a judgment call based on  
4 their own experience, rather than having any  
5 actually written evidence of how often, how  
6 long, etc., and without having interviewed the  
7 worker, which would be helpful. Then, any  
8 information that is known about what's going on  
9 at the site at the time, use of personal  
10 protective equipment, and use of personal  
11 protective equipment, I think, is assumed in  
12 most cases. If there's not documentation of  
13 it, the worker might have information about it,  
14 how reliable is the information, you know, I  
15 don't know, but that may be the best way to get  
16 that information in most cases.

17                   Then, in thinking about all of this,  
18 the industrial hygienist uses their knowledge  
19 and judgment to assign a level of significance.  
20 The procedure manual goes down and defines each  
21 of the categories, so more than incidental but  
22 less than significant and I think this is part

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1 of what Dr. Friedman-Jimenez is pointing out,  
2 that you can have incidental exposures that are  
3 still clinically significant and as written it  
4 doesn't take that into account too well.

5 All right, we can go down to the  
6 next page. So that was the only thing that's  
7 really described. It doesn't really describe  
8 the low, moderate, and high. The reason we  
9 keep on coming back to this is because the word  
10 significant is used in the statute in two  
11 different ways, and the conclusion of the  
12 industrial hygienist that an exposure is  
13 significant can easily be interpreted as that  
14 it was a significant contributor to the medical  
15 condition which is not something that is really  
16 within the industrial hygienist's purview.

17 CHAIR MARKOWITZ: Steve Markowitz, I  
18 have a question. You just said that the act  
19 uses the word significant in two different  
20 ways.

21 MEMBER CLOEREN: Well, I think from  
22 what Ms. Pond read earlier, it's both

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1 significant exposure and significant  
2 contribution to the illness. I think it's in  
3 both parts right? No?

4 CHAIR MARKOWITZ: The act says it  
5 has to be a significant factor.

6 MEMBER CLOEREN: Okay, but isn't it  
7 also exposure? Maybe I misheard.

8 MS. POND: The act does use the term  
9 twice, but I think significant is only in there  
10 once and that's at the beginning of that phrase  
11 where it's a significant factor and the second  
12 part of exposure is that the exposure has to be  
13 related to DOE employment. So, first it says  
14 the exposure must be a significant factor in  
15 causing/contributing to or aggravating and then  
16 it says that the exposure has to be related to  
17 employment and that phrase in the act itself.

18 MEMBER CLOEREN: Okay, so in the act  
19 significant is connected with causation. The  
20 causation decision, whereas in the procedural  
21 manual, well I think it's both ways if we were  
22 to do a search for significant, it shows up in

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1 a lot of different ways in the procedure  
2 manual, but most importantly for our purposes  
3 right now, it's used to describe the exposure,  
4 which can be -- it would not be surprising to I  
5 guess learn that people may interpret the  
6 significant exposure and kind of add that  
7 therefore it's causally related or not a  
8 significant exposure and therefore not causally  
9 related, right?

10 CHAIR MARKOWITZ: So my reaction,  
11 Steve Markowitz, is that as an occupational  
12 medicine physician, is you've got six  
13 categories of exposure, right? You have none,  
14 incidental, more than incidental, and then  
15 three levels of significant and based on either  
16 the report of the patient, the participant or  
17 usually no real industrial hygiene data,  
18 monitoring data. You might have the data of  
19 the occupational health questionnaire, right?  
20 Represents data. I'm hard pressed to divide  
21 the exposures into six different grades based  
22 on that kind of information.

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1                   MEMBER CLOEREN: Marianne Cloeren.  
2           Yeah, I agree. I mean I think that the kind of  
3           the fine parsing out of the different levels  
4           suggests that it's based on data and there's  
5           not a lot of data on which to base the  
6           determinations anyway. So, I agree.

7                   CHAIR MARKOWITZ: But what do the  
8           industrial hygienists think of this? Dr.  
9           Industrial Hygienist?

10                   (Laughter.)

11                   MEMBER VAN DYKE: Mike Van Dyke.  
12           Since you asked, I mean, I think, to me, one of  
13           the problems is that they don't really define  
14           high, moderate and low very well, for one. So,  
15           it kind of leaves it up to the judgment of the  
16           industrial hygienist, and I'll tell you from  
17           experience that industrial hygienists think  
18           very differently about low, medium and high. I  
19           think that's a problem in itself.

20                   I mean, I think it gives you a  
21           framework, it gives you a scale. You can work  
22           with a scale. I don't like the words

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1 necessarily, but there is a scale there.  
2 Probably too fine of a scale, but sometimes  
3 industrial hygienists like precision,  
4 unjustified precision, I should say.

5 CHAIR MARKOWITZ: Preferably  
6 precision based on facts, right, yeah. Mr.  
7 Domina?

8 MEMBER DOMINA: I think different  
9 than you guys do, just because of my  
10 experience, but I also have problems with that  
11 in passing only with the low, medium and high  
12 in our world, let's just say 10 is low, 15 is  
13 medium, 20 high, well, now you can't get your  
14 work done. So, now all of a sudden 10 goes to  
15 20 or 30 or 50 on some measurement that you're  
16 doing, if they're measuring it at all. That  
17 becomes problematic because, you know, like now  
18 everything's run to failure. Well, just  
19 because a light turns on, doesn't mean that  
20 whole thing hasn't failed.

21 You know, same thing, 100 percent  
22 used to be here, 100 percent's here now and you

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1 have to look at it differently. Because that  
2 in passing only is problematic for me.  
3 Somebody could be beryllium sensitized in  
4 passing only, but there's a test to measure  
5 that. It's the same thing as I've had people  
6 go out on the tank farms, four people together  
7 in one instance. Two of them are 5 foot  
8 nothing, two of them are 6 foot 4. The two for  
9 5 foot nothing end up on the ground based on  
10 atmosphere, different stuff pushing the vapors  
11 down, and that stuffs not measured. So, a lot  
12 of this where somebody who has no experience of  
13 being in the field, making a decision that it's  
14 in passing only, it's low but not significant  
15 is not correct. Without them talking to the  
16 people and understanding the type of work --  
17 like I spoke earlier today, when we're talking  
18 about tank farm vapors where you got in  
19 respiratory protection, well they spent  
20 millions and millions of dollars to put stacks  
21 in to get it away from the people, but certain  
22 times of year, the spring and the fall, when

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1 the air gets dense that stuff can get pushed to  
2 the ground. So, that's my two cents.

3 CHAIR MARKOWITZ: Mr. Key?

4 MEMBER KEY: Yeah, I echo Kirk's  
5 concern and summation on it. A low chronic  
6 over a period of time to an individual  
7 certainly could be the causation as opposed to  
8 a significant short burst effect.

9 CHAIR MARKOWITZ: Peak, peak  
10 exposure right?

11 MEMBER KEY: And so that presents a  
12 problem I don't know what the determining  
13 factor or person is thinking. If they see that  
14 it's low significant, but don't have that  
15 worker health questionnaire that that exposure  
16 being low was chronic over a period of 15  
17 years.

18 CHAIR MARKOWITZ: Mr. Catlin.

19 MEMBER CATLIN: Mark Catlin. I have  
20 two thoughts that concern me and I'm not sure  
21 how to deal with them. One is I guess from my  
22 own experience, I've seen the hygiene

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1 definition of significance where it's  
2 interpreted by medical people who aren't  
3 occupational medicine docs and they interpret  
4 that to mean there couldn't have been a  
5 disease, based on that exposure. So, it's  
6 giving industrial hygiene a little more credit  
7 than it should in terms of causation.

8 So I'm concerned if that is --  
9 (Simultaneous speaking.)

10 MEMBER CATLIN: Oh, I'm sorry.

11 CHAIR MARKOWITZ: Could you repeat  
12 that?

13 MEMBER CATLIN: Yeah, and shorten  
14 it. So, I guess I have two concerns and one is  
15 the word significant, how the hygienists field  
16 uses it versus occupational medicine or  
17 medicine. I've just seen in my own experience  
18 where non-occupational medicine docs have  
19 sometimes interpreted industrial hygiene  
20 definition of like low exposure meaning the  
21 person couldn't have disease related to work  
22 and so the claims would be denied in a Workers'

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1 Comp system. So, I don't know if that's  
2 something that's happening here with both the  
3 CMCs and/or the claims examiners and I would be  
4 concerned about that and figure out if we can  
5 address it.

6 The other one is before coming to  
7 the meeting, I was looking through this in  
8 different ways, and I saw some historical  
9 references to exposures, you know, problem  
10 events that were listed. They would have the  
11 short summary that exposure was very low or  
12 exposure was below legal limits, but you also  
13 look at the dates and so some of these are like  
14 1964, some of them are like 1986, and we've  
15 seen this in some of the claims examining where  
16 it's not clear when the IH report will say the  
17 exposures were within legal limits, you're not  
18 sure what time frame, what limits they're  
19 talking about, so that could be incredibly  
20 confusing and misleading, too.

21 MEMBER CLOEREN: Can I just --

22 CHAIR MARKOWITZ: Sure, sure go

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1 ahead.

2 MEMBER CLOEREN: I just want to  
3 embellish a little bit. For people that may  
4 not be aware, I think what Mr. Catlin's getting  
5 to is that the standards at the time may have  
6 not been exceeded, but today that would have  
7 been definitely exceeded because the standards  
8 have changed over time. We know that lower  
9 levels are more dangerous than it used to be  
10 thought. Is that what you were getting at?  
11 Yeah. Thanks.

12 CHAIR MARKOWITZ: I think there were  
13 some comments on this side.

14 MEMBER BOWMAN: Yes, thank you. Aaron  
15 Bowman. Actually, skip ahead, Mark, to your  
16 point, I think that on your first point that  
17 is, in fact, the concern that some of the  
18 claims that we examined had that exact thing  
19 where a CMC stated, IH says this is low,  
20 therefore, it cannot cause disease. So that's  
21 what we're trying to point out.

22 Then back to the point that Jim was

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1 making earlier, you made a point about chronic  
2 versus acute basically. That's exactly why we  
3 made the new table because to just use one term  
4 to describe an exposure, ignores all of  
5 exposure science and that's why we had the  
6 table, right, which was now maybe not fully  
7 going to be used, but it's for those exact  
8 reasons, because the nature of the exposure  
9 makes a difference and it's not -- presumably,  
10 I guess maybe there's one term because we're  
11 leaving it up to the IH to determine an amalgam  
12 of all those things whether it was significant,  
13 which is why we had this working group of what  
14 significance means in the first place.

15 So, we are all the way back to  
16 square one, but we don't want to go around the  
17 same circle again, so it might be helpful to  
18 think about any recommendation we made in the  
19 context of learning what recommendations we  
20 have previously made were not effective and  
21 thinking more forward about them.

22 CHAIR MARKOWITZ: Dr. Van Dyke?

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1                   MEMBER VAN DYKE: Mike Van Dyke.  
2           Yes, I agree with you Dr. Bowman. We feel like  
3           we're running around the same exact circle  
4           again and I was kind of hesitant to jump on  
5           that track, but I agree with the duration,  
6           frequency and intensity of exposure are the  
7           important constructs of exposure. I think I've  
8           said this before, the industrial hygienists and  
9           physicians don't necessarily speak the same  
10          language, and trying to think what the other  
11          person is saying based on a term that's not  
12          defined, is difficult. I think that if we  
13          could get more defined terms, we might get to a  
14          better place because at least there's some  
15          common place people could go to look for that  
16          definition, but without defined terms, we're  
17          going to kind of miss each other in the night a  
18          lot of times.

19                   CHAIR MARKOWITZ: Dr. Cloeren?

20                   MEMBER CLOEREN: I wonder if -- I  
21          have no idea whether this is already done, but  
22          guidance to the CMCs kind of pointing out the

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1 different ways the terminology is used and  
2 providing examples where low exposure might  
3 still mean clinically significant, whether that  
4 might be something that's considered unless  
5 something like that already takes place.

6 MS. POND: This is Rachel Pond. We  
7 don't necessarily send out guidance to the CMCs  
8 that say that exactly, but we also have to keep  
9 in mind that it's not just CMCs that are  
10 issuing these causation determinations, it's  
11 treating physicians. But yeah, we give them a  
12 certain amount of guidance. We have a manual  
13 for them in general terms, but I don't think  
14 that we've laid it out exactly as you've  
15 indicated.

16 CHAIR MARKOWITZ: I just have a  
17 question of clarification. Mr. Vance explained  
18 this to us previously, but I don't recall,  
19 there's something about the word significant  
20 here that's relevant in terms of other  
21 provisions of the procedure manual. If you are  
22 deemed to have a significant exposure of

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1       whatever -- low, medium, high, it gets you  
2       eligible for something. I think it's a  
3       presumption and that's important because the  
4       presumption is a facilitated pathway towards a  
5       successful claim.

6               So, you want it to retain the use of  
7       the word significant because it makes you  
8       eligible for a prize and yet, I guess, the  
9       program decided that you needed something less  
10      than significant in which to characterize  
11      exposure. Did I get that right?

12             MS. POND: This is Rachel. Yes,  
13      that's correct. And some of these presumptions  
14      that are in Exhibit 15 of the procedure manual,  
15      you'll see where it says you had to have had a  
16      significant amount of exposure for this  
17      prolonged period of time or whatever it is  
18      depending on the condition and that is why we  
19      do look for the word significant in the IH  
20      reports when we're looking specifically for  
21      presumptions.

22             CHAIR MARKOWITZ: So that's why it

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1 makes this hard for us to recommend somehow  
2 getting rid of the use of the word significant  
3 here because it ties into other parts of the  
4 procedure manual. My concern about the  
5 relatively new category of more than incidental  
6 but not quite significant is that it's a place  
7 to park a lot of exposures that you don't  
8 understand what they meant. You don't know  
9 what their levels were, and the CMC is going to  
10 interpret that usually as being unimportant.

11 And if it were based on underlying  
12 facts, okay, but it's based on a gestalt and an  
13 impression about what went on. That's a  
14 problem, I think. Dr. Bowman?

15 MEMBER BOWMAN: Yes, thank you. In  
16 terms of these elements and how to utilize the  
17 terminology and the idea that the word  
18 significant is important for many reasons, I  
19 think part of the concerns about the table that  
20 the Department mentioned was just that there's  
21 value to the narrative explanation as well, I  
22 believe that's what I recall from reading in

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1 their response. Maybe if the IH -- we talked  
2 about defining the word significant and the  
3 different definitions of this word across  
4 different fields, perhaps at least whether it's  
5 in the narrative or in the table, if the IH  
6 says, this is significant low, they should  
7 define what elements of the exposure made them  
8 say that. That could help, that way therefore  
9 it's internally defined in the document that  
10 the physician is looking at.

11 CHAIR MARKOWITZ: Michael Van Dyke?

12 MEMBER VAN DYKE: Mike Van Dyke.

13 Dr. Bowman, I agree. I mean, I think  
14 significant is defined here. That is one term  
15 that's defined. The terms that aren't defined  
16 are low, medium and high. I think that if you  
17 asked any occupational medicine physician, you  
18 know, if they're going to make a causation  
19 determination, what do they need to know? They  
20 need to know level of exposure, how often they  
21 were exposed and for how many years because  
22 most of these things are chronic long term

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1 exposures.

2 We've kind of excluded two of those  
3 from this situation right here, so to expect a  
4 CMC to make a decision based on just the  
5 gestalt is pretty difficult. And I'll add that  
6 industrial hygienists don't necessarily know  
7 the answer. I mean, they don't think that -- I  
8 know it takes 10 years, and I'm making this up  
9 by the way. We don't think about, we know it  
10 takes 10 years to get asbestosis from exposure.  
11 That's not the way we think. We think, you  
12 know, we know there's an asbestos standard. We  
13 know what the level of exposure is in relation  
14 to this standard and we know how long a person  
15 is exposed. So, it's definitely a different  
16 thinking process as well.

17 CHAIR MARKOWITZ: Steve Markowitz.  
18 There's a point you made I didn't understand.  
19 You said they are missing two factors? The  
20 rubric is missing two elements?

21 MEMBER VAN DYKE: Frequency and  
22 duration.

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1 CHAIR MARKOWITZ: But isn't low,  
2 medium, high a compilation of -- doesn't it  
3 represent dose, a combination of frequency,  
4 intensity and duration?

5 MEMBER VAN DYKE: Somehow, in a way  
6 that's not defined.

7 CHAIR MARKOWITZ: But would a  
8 definition look like? Because it's going to be  
9 different for each toxic substance.

10 MEMBER CLOEREN: It would look like  
11 a table.

12 (Laughter.)

13 MEMBER VAN DYKE: It'd look like a  
14 table, like we've been --

15 (Simultaneous speaking.)

16 CHAIR MARKOWITZ: It would look like  
17 table, an improved table.

18 (Laughter.)

19 MEMBER VAN DYKE: They use intensity  
20 terms to have the gestalt for all three of  
21 those in one term.

22 CHAIR MARKOWITZ: Right. Go ahead,

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1 Dr. Cloeren.

2 MEMBER CLOEREN: Marianne Cloeren.  
3 I think there was agreement to use the table if  
4 it was determined that an exposure was  
5 significant. I think we got that far for the  
6 significant, which is good. I just had a  
7 follow-up thought related to something somebody  
8 said, maybe Mark, maybe something Jim said. I  
9 don't remember seeing reference in IH reports -  
10 - and I may have missed it, or it may not have  
11 been relevant -- to changing standards. I  
12 think that would be very important to include  
13 as well, like that the standards at the time  
14 this person worked allowed a much higher level  
15 than is considered safe today.

16 CHAIR MARKOWITZ: Dr. Bowman?

17 MEMBER BOWMAN: I know we had talked  
18 about a recommendation along those lines, but  
19 just if a standard is referred to, the date of  
20 that standard, you shouldn't refer to a  
21 standard without stating what the standard is  
22 you're referring to.

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1                   MEMBER CLOEREN: Marianne Cloeren.  
2                   But also, I think a lot of people reading it  
3                   may not take the time to look up whether that  
4                   standard changed, so I think it would be  
5                   helpful for the IH report to point out that the  
6                   standard today is ten percent, you know, of  
7                   what it was at the time that things were within  
8                   limits.

9                   CHAIR MARKOWITZ: Mr. Catlin?

10                  MEMBER CATLIN: Yeah, Mark Catlin.  
11                  If I can just give an example. I was looking  
12                  in the SCM and it was at Los Alamos exposures  
13                  to asbestos and there was a report from -- I  
14                  think it was '86, and it said that the  
15                  exposures were below the OSHA standard from the  
16                  summary report. Well, '86 was actually right  
17                  at the time the standard was changing so were  
18                  had the standard changed from, I'm trying to  
19                  remember the numbers, but it changed by a  
20                  factor of 10 or more and so it would be really  
21                  crucial for that to be in there.

22                  CHAIR MARKOWITZ: Dr. Van Dyke?

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1                   MEMBER VAN DYKE: I think when we  
2 originally talked about this, we talked about  
3 most of us think in terms of today's  
4 contemporary standards in terms of low, medium  
5 and high. So, if we're going to come up with  
6 some sort of definition, it needs to be  
7 relevant to today's standards and I think that  
8 Dr. Cloeren mentioned that by saying that the  
9 standards were much higher than they were  
10 before, now we're adding another one of those  
11 1995 statements that we don't want to bias it  
12 that way. Just because the standards were  
13 higher doesn't mean they were exposed to more.

14                   MEMBER CLOEREN: That's true, yeah.

15                   MEMBER VAN DYKE: So, we don't want  
16 to bias it the other direction either.

17                   CHAIR MARKOWITZ: Yeah, Steven  
18 Markowitz, the other problem is that I mean if  
19 you're going by OSHA, they've changed very few  
20 standards over the years, and they have very  
21 few specific standards. If you're going by --  
22 I don't know how DOE standards have evolved

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1 specifically, I don't know what they were  
2 before 1995, but if you're going by the  
3 industrial hygiene community which has lowered  
4 recommended standards over the years, so which  
5 standards? I think it's too much information,  
6 and there's too limited coverage by legal  
7 standards to make it relevant.

8 But here's my question: You know,  
9 given what Mr. Domina was saying before, does  
10 it really make any sense to have a distinction  
11 between incidental and more than incidental?  
12 Both of which reside below low. Dr. Cloeren?

13 MEMBER CLOEREN: Do we know why that  
14 change was made? Was it in response to  
15 something we recommended?

16 (Laughter.)

17 CHAIR MARKOWITZ: Right, I think we  
18 know that, no.

19 (Laughter.)

20 CHAIR MARKOWITZ: I don't know, Ms.  
21 Pond, whether you or Mr. Vance want to respond  
22 to that or not. If not, that's fine.

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1 MS. POND: I don't know for sure. I  
2 wouldn't want to admit -- I wouldn't want to  
3 confirm or deny that statement.

4 (Laughter.)

5 CHAIR MARKOWITZ: I know Mr. Vance  
6 gave us an explanation before actually.

7 MS. POND: John, did you want to  
8 address that?

9 MR. VANCE: Yeah, I mean this was  
10 our attempt to -- we were getting rid of the  
11 language that spoke to regulatory limits  
12 because there was a very big concern about  
13 trying to explain what that meant so we had to  
14 come up with some other type of way to describe  
15 this that took into consideration lots of  
16 different factors and so the industrial  
17 hygienists when they were looking at this and  
18 considering how to deal with this reality of,  
19 yes, we don't really know what standard applied  
20 at what time.

21 You have to look at the totality of  
22 the information that you have in front of you

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1 and sort of come to some sort of estimate about  
2 what the industrial hygienist thinks could have  
3 been likely occurring and as they got into the  
4 discussion about like from the '90s on, really  
5 you would expect to see things in the file and  
6 that doesn't necessarily mean that it was a  
7 completely safe operating circumstance, it's  
8 just we've got to see something. We want to  
9 see something more compelling or convincing to  
10 show us that there was something that would've  
11 been an occupational risk or a hazard for this  
12 individual employee and then this language sort  
13 of came out of those discussions.

14 There was a lot of debate about it  
15 and I think that just from the discussion, this  
16 is not easy. There's no easy answer. Our  
17 folks and the scientists that work on this  
18 struggled with this quite a bit to try to come  
19 up with something that sort of melded all the  
20 viewpoints that have been out there. I think  
21 it was informed a little bit about the  
22 conversations the Board had.

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1                   CHAIR MARKOWITZ: Thank you. Any  
2 further comments on this issue? I mean I  
3 wanted to come back to this because we had  
4 begun this discussion and I think it's  
5 important. We don't need to formulate a  
6 recommendation, although we could, not this  
7 moment, but by tomorrow morning, for example,  
8 if we thought there was a direction we wanted  
9 to head in.

10                   I remain bothered by the fact that  
11 there are six levels. There is very little  
12 quantitative data, and there's the occupational  
13 questionnaire and yet the industrial hygienist  
14 is tasked with choosing one of six different  
15 levels to pass along to the CMC to make a  
16 decision.

17                   Okay, so if there are no further  
18 comments or questions, we're going to take a  
19 break actually. Let's just discuss tomorrow  
20 morning for the moment. It's 3:15 now, our  
21 public comment period starts at 4:15, we would  
22 come back at 4:15 in case any public commenters

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1 show up, but there are a few things we're going  
2 to deal with tomorrow. One is, hopefully,  
3 we'll have, I think, a recommendation or at  
4 least a response on the issue of industrial  
5 hygiene on the table and the characterization  
6 that we discussed earlier.

7 I think we should consider either a  
8 response or a recommendation regarding CMCs and  
9 quality and validity. Again, it could be -- if  
10 we can agree on a path, it could be a  
11 recommendation, or it could be agreement on  
12 various elements of a response whereby we  
13 disagree and why we disagree with the decision  
14 the Department made in response to our  
15 recommendation. So, we would address those two  
16 things.

17 I think if there's something that we  
18 want to say about this issue of significance,  
19 we could formulate that tomorrow. Then a brief  
20 discussion, we've been requested to look at the  
21 IARC 2A Carcinogens and I think Paragon has  
22 identified them, including the candidate human

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1 cancers that would be concluded in this SEM and  
2 the request is that we review that not at this  
3 meeting, but sometime in the coming months and  
4 then weigh in with the Department about our  
5 proposal.

6 Are there any other issues that we  
7 should discuss? Because we will have time  
8 tomorrow to open up new issues. Again, if you  
9 think of any tonight, we can raise them  
10 tomorrow, it's fine. Dr. Bowman?

11 MEMBER BOWMAN: I was just going to  
12 say in your list of to-do items for the Board,  
13 one of them, which, I'm sorry if I didn't hear  
14 it, we were going to provide some additional  
15 follow-up questions on the SEM.

16 CHAIR MARKOWITZ: Right.

17 MEMBER BOWMAN: With examples?

18 CHAIR MARKOWITZ: Right. Now that  
19 was going to be done after the demonstration of  
20 the SEM or?

21 MEMBER SPLETT: Probably before.

22 CHAIR MARKOWITZ: Okay. And do we

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1 need further discussion at this meeting about  
2 that, or is that something that -- tomorrow?  
3 Okay fine.

4 MS. POND: This is Rachel. We do  
5 have, there were a couple of questions from the  
6 follow-up questions that we still had. We can  
7 provide you those in writing. There were only  
8 like two left, I think, on that list so we were  
9 planning to provide those responses that we  
10 talked about today in writing as well, so we'll  
11 do that before the next subcommittee meets and  
12 does the demonstration.

13 CHAIR MARKOWITZ: Okay.

14 MEMBER BOWMAN: For example, the  
15 examples, Gail, that you walked us through the  
16 differences and since if we need full Board  
17 approval to put those in in order to get a  
18 response for us to evaluate, it would be good,  
19 I think, to have that written up tomorrow and  
20 voted on. If we can submit the questions  
21 without the full Board approval then not.

22 CHAIR MARKOWITZ: Yeah, I don't

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1 think we need full Board weigh in on the  
2 questions.

3 MEMBER BOWMAN: Okay.

4 (Off-microphone comments.)

5 CHAIR MARKOWITZ: And when we have  
6 the demonstration, it needs to be a subset of  
7 the Board. It can't be the entire Board, which  
8 means that it can be all but one Board member,  
9 so as many people as want to participate. I'm  
10 sure there will be at least one who will be  
11 otherwise busy, so there won't be a problem.  
12 Yeah, Dr. Cloeren?

13 MEMBER CLOEREN: I do think it's  
14 important for that demo that it be set up in a  
15 way that it permits both Paragon and Gail and  
16 other --

17 CHAIR MARKOWITZ: Board members.

18 MEMBER CLOEREN: Yeah, Board  
19 members, to be able to show. I think the demo  
20 of how it works is great, but I think the demo  
21 of the problems that people are finding, I  
22 think, would be just as important. So, I think

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1 it should be a two-way interactive  
2 demonstration if that's possible.

3 CHAIR MARKOWITZ: Does that seem  
4 possible, Ms. Pond?

5 MS. POND: Yes, I think so. I mean  
6 I know she has examples already, so it will be  
7 interactive, especially if we can do it face-  
8 to-face. There will be an opportunity for  
9 that, more opportunity for that.

10 CHAIR MARKOWITZ: Face-to-face?

11 MS. POND: If not, I mean, we can  
12 probably work it out through WebEx or  
13 something. I don't know exactly what the plan  
14 would be.

15 CHAIR MARKOWITZ: Yeah, okay. Okay,  
16 so if there are no other comments or questions  
17 then why don't we suspend until 4:15.

18 (Whereupon, the above-entitled  
19 matter went off the record at 3:21 p.m. and  
20 resumed at 4:15 p.m.)

21 CHAIR MARKOWITZ: Okay, let's begin  
22 the new session. So the public comment session

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1 is now open. For those of you who are online  
2 participating, if, as members of the public,  
3 you wish to make a comment, you're welcome to  
4 do so. If you could indicate on the WebEx, I  
5 think, by raising your hand then the people  
6 here can see you and then we can put you on the  
7 schedule, which is quite short at this point,  
8 so please indicate if you'd like to speak  
9 within the next five minutes or so.

10 So, let me welcome Ms. D'Lanie Blaze  
11 as our first speaker.

12 MS. BLAZE: How's that?

13 CHAIR MARKOWITZ: Good.

14 MS. BLAZE: Thank you. I'm D'Lanie  
15 Blaze of CORE Advocacy for Nuclear and  
16 Aerospace Workers. I mainly represent  
17 claimants who are affiliated with Santa Susana  
18 Field Laboratory and its related work sites,  
19 Canoga and DeSoto Facility, near Los Angeles,  
20 California. It's a privilege, as always, to  
21 address the Board and I thank you all for  
22 traveling to be here and for offering the

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1 opportunity to provide public comment.

2 Today, I want to talk about the  
3 removal of information from the SEM for Area 4  
4 of Santa Susana. In 2017, the propulsion  
5 workers and related activities were removed  
6 from the SEM in response to a FOIA where I  
7 requested information about the directive and  
8 the rationale to remove this information. The  
9 contractor, Paragon, indicated that it had  
10 removed propulsion workers and activities  
11 because these employees are not considered to  
12 be eligible for the program under Part E, but  
13 this is incorrect. These workers have always  
14 been eligible for the program. Not only is  
15 this incorrect, no other information was  
16 provided regarding where the directive to  
17 remove the information had originated or what  
18 documentation was used to support the removal.

19 Mr. Turcic had authored the  
20 Established Eligibility Decision for Area 4  
21 Santa Susana during his time as the program  
22 director in 2005. In his decision, the

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1 propulsion workers certainly were never  
2 excluded. In fact, the decision that he issued  
3 provides that any Department of Energy  
4 contractor employee who can establish  
5 employment for the company at a location where  
6 DOE conducted operations may be considered to  
7 be eligible for the EEOICPA, and that means any  
8 DOE contractor or subcontractor employee who  
9 performed job duties inside Area 4.

10 Based on the multiple Department of  
11 Energy-funded propulsion programs that occurred  
12 in Area 4, which began in the 1950s, there was  
13 no basis to remove these workers and their  
14 activities from the SEM. These DOE funded  
15 operations began in the '50s, the locations  
16 where the work occurred in Area 4 are still  
17 included in the SEM and Paragon is in  
18 possession of worker DARs showing verified Area  
19 4 employment among propulsion workers, who  
20 performed associated activities inside the  
21 covered area.

22 So, it was shocking that this

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1 information was removed, and to date, Paragon  
2 has not disclosed at whose direction this  
3 occurred or provided any information as to what  
4 information was used to support this move. We  
5 have had some issues with Santa Susana since  
6 the program's outset. Mr. Turcic indicated in  
7 the 2005 eligibility decision that it had been  
8 DOE and Boeing's goal in 2002 to limit the  
9 number of Santa Susana workers who would be  
10 considered covered under the EEOICPA.

11 This resulted in a three-year  
12 argument with Department of Labor during which  
13 all claims associated with Santa Susana, Canoga  
14 and DeSoto were placed into pending status.  
15 During this period, several workers died  
16 without ever understanding why their claims had  
17 stalled. Since then, we have had multiple  
18 incidents, all verified by DOE and the national  
19 office, where Boeing has been found to  
20 routinely submit incomplete and misleading  
21 information during the employment verification  
22 process, resulting in the summary

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1 disqualification of workers who clearly qualify  
2 for compensation and medical benefits under  
3 both Part E and Part B.

4           There's no shortage of well-  
5 documented examples, and I can keep you guys  
6 here for a week going over them in detail, but  
7 suffice to say, from establishing covered  
8 employment to providing incomplete information  
9 during the creation of the NIOSH site profile  
10 that resulted in the omission of nearly 50  
11 radiological facilities that operated at Area 4  
12 in excess of 50 years, all verified by the  
13 Federal EPA during their historical site  
14 assessment of Area 4, we have documented  
15 efforts by the contractor to seriously engage  
16 in instruction of the program.

17           It came as no surprise to me to  
18 discover that the propulsion workers who were  
19 removed from the SEM seemed to make up the  
20 largest number of employees who DOE and Boeing  
21 had initially hoped to exclude from the EEOICPA  
22 back in 2002 and this raises some concerns

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1 about Paragon's failure to disclose where the  
2 information came from to support the removal of  
3 the information from the SEM.

4 So I would respectfully encourage  
5 all involved to ensure that no information is  
6 ever removed from the SEM based on a  
7 contractor's assertion or those of any agency,  
8 but rather through the careful and objective  
9 evaluation of documentation that effectively  
10 contradicts that which was initially used to  
11 justify the inclusion of the data in the first  
12 place.

13 Ideally, it is my humble opinion  
14 that such an objective and qualified evaluation  
15 would probably be best conducted by the Board.

16 So those were my prepared comments,  
17 but since I'm the only commenter present, I  
18 wonder if I might touch on a few other topics  
19 just very briefly, if I can take some extra  
20 time?

21 I think that it is quite valuable to  
22 have leadership here, but my observation is

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1 that they're very adept at informing all of us  
2 about how things should be happening, and  
3 that's not how things are actually happening at  
4 the claims examiner and the authorized  
5 representative and the claimant levels. For  
6 example, the DARs are still not being reviewed  
7 thoroughly, and since we have witnessed the  
8 death of institutional knowledge with the  
9 decision to divert claims away from seasoned,  
10 experienced claims reviewers and create a  
11 situation where claims examiners are, for the  
12 most part, totally confused because they lack  
13 familiarity with site specifics and the unique  
14 complexities associated with so many work  
15 sites.

16 CE's routinely express that they're  
17 just completely overwhelmed. They're making  
18 inappropriate decisions that require a hearing,  
19 oftentimes resulting in the need to re-do dose  
20 reconstructions multiple times or re-do IH  
21 evaluations because of information that they  
22 missed either by not reviewing the DAR or by

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1 not understands how to identify covered  
2 employment or other information that is  
3 significant and relevant.

4 In my review of my current case load  
5 of Santa Susana cases, for example, we used to  
6 always have our claims adjudicated by Seattle  
7 District Office, but now it appears that the  
8 majority of my cases have been routed to  
9 Jacksonville District Office, which does not  
10 have the benefit of established institutional  
11 knowledge over the course of the program.

12 Every claim, even SCC claims, are now routinely  
13 heading for hearings and even when we're at a  
14 hearing, we still have to educate the hearing  
15 reps about site complexities and the published  
16 guidance from the national office about which  
17 they remain unaware and we're five years into  
18 the removal of the jurisdictional purview.

19 So I reiterate that the decision to  
20 divert claims away from the regional district  
21 offices was the single most damaging decision  
22 that could have been made for the claimants.

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1 They can no longer count on qualified, thorough  
2 review of their cases.

3 Lastly, speaking of Jacksonville  
4 District Office, I currently have a claim there  
5 where the claimant was coded terminal back in  
6 March, and when I spoke to the claim examiner  
7 to encourage his swift correction of several  
8 errors in this claim, he responded by saying  
9 that since the claimant was coded terminal so  
10 long ago, but still hadn't died, it was the  
11 District Office's position that he was never  
12 actually terminal and he had no impetus to move  
13 quickly on the claimant's behalf. He requested  
14 a deathbed terminal statement from hospice, and  
15 they indicated that they're ethically  
16 prohibited from making such a specific  
17 declaration and could only provide a letter  
18 indicating that the claimant has six months or  
19 less to live.

20 I called that CE on Friday to  
21 discuss the urgent remount order issued by FAB  
22 in the second hearing that we've had on this

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1 case. Today is Wednesday, and as of yet, I  
2 have not received a return phone call on behalf  
3 of this claimant. He's also had two dose  
4 reconstructions due to overlooked covered  
5 employment and other errors that have occurred  
6 during the claims process, and I think if we  
7 had a more seasoned and experienced claims  
8 examiner at the very beginning, this claimant  
9 would not be experiencing this level of delay.

10 So, I respectfully submit the  
11 jurisdictional purview should be restored. The  
12 claimants deserve thorough and qualified review  
13 by seasoned CEs who have some familiarity with  
14 their work sites and five years into this,  
15 we're still seeing examples of why this was a  
16 really bad idea. That's it for me today. As  
17 always, thanks for the opportunity to bring  
18 information.

19 CHAIR MARKOWITZ: Thank you. Will  
20 you be submitting written comments?

21 MS. BLAZE: If you'd like.

22 CHAIR MARKOWITZ: Well, certainly

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1 the SEM part.

2 MS. BLAZE: Okay.

3 CHAIR MARKOWITZ: Let me ask,  
4 Carrie, do we get a verbatim transcript of the  
5 public commentary?

6 MS. RHOADS: Yes.

7 CHAIR MARKOWITZ: But, still,  
8 because we may be having our demonstration with  
9 the SEM sooner rather than later, formulating  
10 our questions, if you could submit the written  
11 comments about the SEM sooner rather than  
12 later, that would be helpful.

13 MS. BLAZE: Certainly.

14 CHAIR MARKOWITZ: Thank you.

15 MS. BLAZE: Thanks.

16 CHAIR MARKOWITZ: Carrie, anybody  
17 else?

18 MS. RHOADS: No, I think that's it.

19 CHAIR MARKOWITZ: Okay. So then we  
20 are finished for today. Tomorrow, I don't have  
21 the agenda in front of me. What time will we?  
22 8:30, I think, tomorrow? Yeah, 8:30 tomorrow.

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1 Anything you need to say, Ryan, at the close of  
2 the meeting today?

3 MR. JANSEN: No, I think that's it.  
4 The meeting is adjourned.

5 CHAIR MARKOWITZ: Thank you, all.

6 (Whereupon, the above-entitled  
7 matter went off the record at 4:27 p.m.)  
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